S. HRG. 102-863, PT. 1

COMPREHENSIVE HEALTH CARE REFORM AND COST CONTAINMENT

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

MAY 6 AND 7, 1992

(Part 1 of 2)

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

58-769—CC WASHINGTON : 1992

S361-2

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-039538-0

COMMITTEE ON FINANCE

LLOYD BENTSEN, Texas, *Chairman*

DANIEL PATRICK MOYNIHAN, New York	BOB PACKWOOD, Oregon
MAX BAUCUS, Montana	BOB DOLE, Kansas
DAVID L. BOREN, Oklahoma	WILLIAM V. ROTH, JR., Delaware
BILL BRADLEY, New Jersey	JOHN C. DANFORTH, Missouri
GEORGE J. MITCHELL, Maine	JOHN H. CHAFEE, Rhode Island
DAVID PRYOR, Arkansas	DAVE DURENBERGER, Minnesota
DONALD W. RIEGLE, JR., Michigan	STEVE SYMMS, Idaho
JOHN D. ROCKEFELLER IV, West Virginia	CHARLES E. GRASSLEY, Iowa
TOM DASCHLE, South Dakota	ORRIN G. HATCH, Utah
JOHN BREAUX, Louisiana	

VANDA B. MCMURTRY, *Staff Director and Chief Counsel*
EDMUND J. MIHALSKI, *Minority Chief of Staff*

CONTENTS

WEDNESDAY, MAY 7, 1992

OPENING STATEMENTS

COMMITTEE PRESS RELEASE

CONGRESSIONAL WITNESS

PUBLIC WITNESSES

THURSDAY, MAY 7, 1992

OPENING STATEMENTS

COMMUNICATIONS

COMPREHENSIVE HEALTH CARE REFORM AND COST CONTAINMENT

WEDNESDAY, MAY 6, 1992

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Baucus, Bradley, Mitchell, Pryor, Riegle, Daschle, Breaux, Packwood, Roth, Danforth, Chafee, Durenberger, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H–17, April 10, 1992]

BENTSEN CALLS HEARINGS ON HEALTH CARE REFORM; FINANCE CHAIRMAN NOTES SKYROCKETING COSTS OF NEEDED CARE

WASHINGTON, DC—Senator Lloyd Bentsen, Chairman of the Senate Finance Committee, Friday announced hearings on comprehensive reform of health care costs.

Bentsen (D., Texas) said he has called a series of hearings, beginning with two early next month, to focus on cost containment in the face of sharply increasing costs.

The hearings will be at *10 a.m. Tuesday, May 6, and Wednesday, May 7, 1992* in Room SD–215 of the Dirksen Senate Office Building.

"Health care costs are skyrocketing, costing Americans millions of dollars and depriving them of needed medical care. In 1980, health care spending in America was less than $250 billion. This year, it's expected to exceed $800 billion. It's getting worse. That figure is expected to more than double—more than $1.6 trillion—by the year 2000," Bentsen said.

"We want to take a close look at a number of bills proposing comprehensive health care reform that have been referred to the Finance Committee. The President has outlined a proposal. Once it's introduced and he provides details of his plan, we can examine it as well."

Bentsen said the May 6 hearing will be an overview of proposals, the May 7 hearing will focus on approaches to controlling the rate of growth in health care costs, and subsequent hearings will examine other aspects of comprehensive reform proposals.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. If you would please take your seats and cease conversation, the hearing will get under way.

Today the Finance Committee begins a series of hearings on proposals for comprehensive reform of the health care system of this country.

These hearings follow up on work that the committee initiated last year with a series of hearings probing the problems of high

and rising health care costs and the lack of universal access to health insurance coverage.

Reforming our health care system will not be simple, nor will it be easily achieved, nor will it be without controversy. But I think that the American people are counting on us to sort through those issues, to make the difficult choices, and to develop legislation that, when enacted, will give them the assurance that affordable health care will be available when they need it.

And these hearings will play a key role in helping us meet that challenge. We have pending before this committee many thoughtful bills. A number of them have been presented and introduced by members of this committee; bills by Senators Mitchell, Packwood, Rockefeller, Chafee, and Daschle.

We also have a conceptual outline for changes in the health care system from the President, but we do not have the details of that legislation yet proposed so that we can consider it in committee. When that is done, we will be delighted to consider it.

The series of hearings beginning today will explore the various proposals for reform. First, we will hear from Congressional Budget Office Director Bob Reischauer. He will be followed by a very distinguished panel of experts in the health care field and by authorities on public opinion about health care reform.

These witnesses have been invited to provide a road map to guide the committee through its consideration of the different proposals for cost containment and improved access to health care that will be explored later in hearings.

Tomorrow's hearings will focus specifically on approaches for slowing growth in health care spending. And at that time we will hear the views of the administration and others on this critical aspect of health care reform.

We will hold additional hearings in June to examine very specific approaches for comprehensive reform in more detail. A hearing on June 9 will focus on proposals for expanding employment-based health insurance coverage.

On June 16, the committee will hold hearings on proposals for instituting universal coverage through public health insurance programs. And then proposals for tax incentive-based health care reform will be examined in hearings on June 18.

Earlier this year, the committee approved S. 1872, the Better Access to Affordable Health Care Act, which was introduced by Senator Durenberger and myself, along with the Majority Leader and others on this committee. The Senate passed this measure in March as part of the tax fairness legislation.

Because the House had not yet acted on these provisions, they were not included in the conference agreement that was ultimately vetoed by the President. We are awaiting action by the House to see how far we will be able to move on the provisions of S. 1872 this year.

One of the points I want to make clear, no mistake about it, the Better Access bill is intended as a first step toward health care reform, addressing some of the more egregious problems in our health care system. But it is not a substitute for comprehensive reform plans under discussion in these hearings.

The Chairman of this committee is committed to comprehensive health care reform, which I think is necessary. Whether or not we take these first steps, we are not going to lose sight of comprehensive health care reform.

It is a critical part of the national agenda. And I look forward to the guidance that our witnesses will provide so that we can begin to move on comprehensive health care reform as soon as possible.

I would say to my colleagues on the committee, we have an excellent group of witnesses and I want to be certain that we have adequate time to question them at some length.

So, I am going to ask, other than the Ranking Member, I am going to ask all of my colleagues to hold their statements to 2 minutes, and then we will introduce the rest of the statements for the record. I yield to Senator Packwood.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. I will hold mine to 2 minutes, Mr. Chairman. As we start these hearings, there are two major issues that face us. One is coverage, and the other is cost containment. Most of the plans we have considered are pretty good in coverage; relatively few of them, I find, are good in cost containment.

The kind of plans that we have to look at basically fall into four categories: the so-called single-payer system where we will wipe out all of the health insurance in this country and we will collect all of the money in Washington and we will pay all the bills and set all the fees. I cannot imagine that system being efficient, or, in the long run, fair.

We can go to the "play" system, and the bill that I have introduced would be just "play." That is, an employer mandate with tax incentives to have employers provide coverage for their employees.

You can go to a "pay or play" system, slightly different than the "play," where if you do not want to cover your employees, you can opt out, pay some money to the government, and the government will cover them.

You can go to the administration's provisions, and, by and large, I regard the administration's provisions as good, but not as going far enough. Those are the alternatives that we are considering.

I hope all of the witnesses can address themselves to both of those issues—cost and coverage—so that when we are ready to act we can pass a bill that will make sure that the average American worker has some kind of protection that is decent by any standard and that we have some kind of cost containment that, by our standards and others, we can say is effective cost containment.

The CHAIRMAN. Let me see. In the order of arrival, Senator Durenberger.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, I appreciate the hearing. I appreciate the opportunity to be responding to S. 1872. And I do not appreciate the fact that our efforts are referred to as incremen-

tal, because I think some of the alternatives are more incremental than ours.

But let me just quickly trace what I understand to be the subject of this particular session. My experience in this committee now covers about 14 years. The end of the 1970's was when we begun to try to control costs.

It was not that we did not anticipate cost problems; we did. Richard Nixon, among others, did. We tried to control costs in the 1970's by restraining the supply of providers in this country.

In the 1980's we tried to control costs by managing those costs through some kind of averaging system. Right here was the DRG's and then the RBRVS. We did not touch the system itself, which is basically a system which pays for services. We just tried to average those service prices out. Or, we created something called managed care, which, at least in the beginning, was only managing the costs in that system.

Now, in the 1990's, we have adopted basically the philosophy of Gramm-Rudman-Hollings, which is, we need to recognize our limits, we need to define those limits in dollar terms, we need to express them in terms like volume performance standards for RBRV's, or national budget, or state budgets, or organizational budget, or organizational financial limitations.

The question before us today, at least my question to these witnesses, and I know they are more than able to respond to them, is how, within those limits if we adopt them, are we actually going to see change?

Is a change going to come just from reducing prices to providers? Is a change going to come from lowering quality? Is the change going to come from rationing services?

Or, are we going to do the one thing that nobody else has tried in the world yet, and that is to build productivity into the greatest pluralistic health and medical delivery system the world has ever seen.

And, so, I appreciate the opportunity to be here. Hopefully, during the course of my questions I will be concentrating on how we do better for less in this system. These witnesses, I think, are more than capable of responding to that.

[The prepared statement of Senator Durenberger appears in the appendix.]

The CHAIRMAN. Senator Chafee.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman. I commend you for holding these hearings. And, as you stated, I do think we have an outstanding group of witnesses.

A number of solutions to our health care problems have been offered to this committee and in the Congress. I think we all recognize that there are advantages and disadvantages associated with each of these approaches.

Certainly, under every approach some segments of our population will benefit. There is no question about it. Other segments, however, may end up with a benefit plan which is not as generous as the one they currently have.

Much as we would like to believe it, no solution will guarantee access to health care for every American while also lowering the cost of health care and at the same time providing high technology and high quality care on demand.

We have got to realize that there is no such thing as more for less. Through hearings such as this, we will have an opportunity to go into more detail and ask questions about the various approaches.

Mr. Chairman, last week I was joined by 12 of my Republican colleagues, some of them members of this committee, in sending a letter to the Majority Leader, Senator Mitchell, and asking that we begin to meet to develop a bipartisan approach to health care reform so that we can do something this calendar year. We met with Senator Mitchell last week, and I hope that we can begin the process in the near future.

I look forward to hearing what the witnesses have to say today and to working with colleagues on both sides of the aisle in the coming months to enact comprehensive health care legislation. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. Mr. Chairman, I think all of us want to do what all Americans want. And that is, having the peace of mind that they will have affordable, high-quality, accessible health care. That obviously is not the case today, and we owe it to the American people to help give them what they want and that which they deserve.

I also believe that it is going to be a very, very difficult undertaking because Congress is grid-locked. We are not addressing other needs. Who is to say that we in the Congress are going to sufficiently address this need?

It is a test of extraordinary leadership of the Congress, that is, going back to all of the interest groups, whether they be doctors, seniors, hospital administrators, the insurance industry, and telling them that each of them is not going to get what everyone wants.

We are in an era of limits. People cannot have everything they want. And I urge all of us as we go through these plans and these various proposals to swallow some pride, not be too wedded to each of our own proposals and programs, and stand up to interest groups; working with them, but working for a solution where the whole is actually greater than the sum of all the parts.

It is extraordinary difficult, particularly in this election year. But, frankly, that is why we are elected; that is why people sent us here.

And I urge all of us, not only as Senators, but as private citizens and as representatives of various proposals, to work for that common good of comprehensive, high-quality, affordable, accessible health care for America, finally. Thank you.

The CHAIRMAN. Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you, Mr. Chairman, for this very important hearing on a very important issue. I hope the committee, under your leadership, will be able to help lead us out of what appears to be a policy log jam at the Federal level on this issue.

But while we pursue greater consensus here in the Congress, it is also very important to have a continuing discussion with our constituents on this issue to see if we cannot help create a greater consensus at the grass roots and a stronger relationship between the way policymakers approach this issue and the way the average citizen approaches it.

As one of our witnesses today will point out, there is certainly a very clear and a very disturbing difference between the way policymakers think about this issue and the way the average citizen thinks about it.

Under such circumstances, there is certainly considerable potential for undertaking reforms that befuddle and outrage the citizenry.

With a goal of helping to develop better understanding of reform proposals and a greater degree of consensus on the reform issues, I held a health care system reform conference in Des Moines 2 weeks ago, and I hope to have additional such meetings in other parts of my State.

About 600 people attended on a week day, which I took to be an indicator of a high level of interest on this issue in my State. Fully half of them came from outside Des Moines. Thirty-four percent came from small-town and rural Iowa.

We discussed the major reform models being considered at the national level, as well as some of the reform initiatives under way in the States. I feel pretty sure that the people who attended this meeting knew more when they left than they did when they started.

I highly commend this kind of event to my colleagues. I know that some of them have already held such meetings. It seems to me that this is one way for us to generate useful discussion at the grass roots on this issue so that we get a critical mass of understanding that it seems to me is very necessary for us to get 51 votes or more here in this body.

The CHAIRMAN. Thank you. We have the Majority Leader, Senator Mitchell.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, I join our colleagues in commending you for holding this, the first in a series of hearings intended to examine the health care crisis and to review and consider various proposals to reform our health care system.

Access to affordable health care is a fundamental right of every citizen in a democratic society. Any debate must begin with that conviction. Yet, it is a right not realized by millions of Americans.

We have a responsibility to them and to others whose access to care is jeopardized to see that every American has access to good care. I want to express in the strongest possible terms my intention

to move forward this year in attempting to reform our health care system.

This is a matter of urgency. It cannot wait for the next century, or the next election. Our current health care system is failing millions of American families, resulting in bankruptcy for many, worsening of illness for others, and even death for some who might have been saved with timely and appropriate care.

A number of health care bills have been introduced in the first session of this Congress; some calling for a single-payer system; some for an expansion of the employer-based system; and still others proposing modest reform.

Last year I joined with a number of other Senators to introduce comprehensive health care reform legislation: Health America.

Our proposal builds upon the current employer-based health insurance system while providing access to care through a public plan for those who do not have access through employer-based insurance.

We have proposed a reform plan which builds on our country's existing employer-based system. It is a middle ground between those who advocate a government-run, single-payer system, like Canada, and those propose much more limited steps.

While the design of a reform plan is important, what is most important is that any comprehensive plan meet three fundamental objectives.

First, and most important, it must control costs. The rising cost of health care is a problem for every government, including and especially the Federal Government, every business, and every family in America; it must assure access to care for all Americans; and it must emphasize preventive care.

The debate goes on about how best to reform the system. We must commit ourselves to the objectives of controlling cost and providing access to care. We offer our legislation as one serious proposal; not the only solution, not the perfect solution.

We welcome constructive criticism of the bill. We are open to revising its provisions in an effort to improve it. I look forward to working with members of this committee on both sides of the aisle to move toward the enactment of comprehensive reform legislation.

But, Mr. Chairman, we must recognize that no comprehensive legislation can become law without the President's participation and active involvement. That has not occurred.

To this moment, after 3 years of study, 3 months after the President gave his speech containing an outline of his plan, we do not yet have a legislative proposal from the administration. There has been a lot of criticism of other proposals.

I hope we will get one today for discussion in these hearings. It will be a very constructive and forward step for the administration to come forward with a proposal, join the debate, and out of it I hope will come comprehensive legislation on which all the members of this committee can agree and we can enact this year.

The CHAIRMAN. Thank you. Gentlemen, some of you did not hear the statement of the Chair at the opening of the hearings. I would ask you to keep your opening statements to 2 minutes and put the rest of it in the record because we have a number of very excellent

witnesses we want to hear and spend some time questioning. Senator Breaux.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you, Mr. Chairman. I really congratulate you for having these hearings. A person's good health is truly their most valuable possession. Too many Americans are really frightened to death that their health is in jeopardy. And it is not because we do not have good doctors or fine hospitals or drugs that work, it is because too many Americans feel that they have access to none of those things.

The problem is, good health should not be Republican, nor should it be Democratic, but it should be something that all Americans can count on, that they work for, and that ultimately they will be able to have access to. Our challenge is, I think, not to look to blame anybody, but certainly is to produce a workable solution, not to produce press releases.

So, I think this committee is on the right start towards hearing out all of the proposals, laying them on the table, debating them fully. And I am very pleased to hear our Majority Leader point out that he intends to push for action in this Congress. I think the American people expect no less from us. I am hopeful that we can produce up to their expectations. Thank you.

The CHAIRMAN. Senator Hatch.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman. I also want to compliment you for holding these hearings. I think they are critical. The witnesses you have today, I do not know that you could find better witnesses. They will, I think, be very enlightening.

I would put my statement in the record, but I have to say that it seems to me that any health care reform needs to be comprehensive, and it is going to have to include Medicaid reform, Medicare reform, medical liability reform, antitrust reform, insurance reform, much like the distinguished Chairman's bill is doing, and maybe even a little bit more, and regulatory reform, as well as health promotion and disease prevention, including testing, pre-screening, and other approaches that will help us to avoid a lot of the illnesses and problems that we have in America, plus expansion of community and migrant health centers. And we could go on and on.

But I think that all of that has to be part of a comprehensive health program if we are really going to try and solve these problems, along with a whole raft of cost containment approaches.

Tomorrow we will meet as a task force on cost containment. We will listen to Mr. Enthoven, and others. I have to say that nothing is going to work without coming up with some cost containment.

With regard to my friend, the distinguished Majority Leader's comments about this is a fundamental right, I have to say that it is an important consideration, an important thing for American citizens.

I would not call it a constitutional, fundamental right, but I do think it is like food, shelter, and the right to have a job. And those are very, very important things. It is not something that the government has to pay for, which would be a fundamental constitutional right, in my opinion.

But it is an important obligation for us to come up with the solutions here. But I would not want to have it considered a constitutional, fundamental right that government has to do, regardless. This is a complex subject. There are so many different aspects and facets to it that you cannot just categorize it in a political, fundamental right term. So, I just want to make that point and thank the Chairman again for holding these hearings. I think they are very important, and you are doing a terrific job.

Senator MITCHELL. Mr. Chairman, might I just respond to make the record clear, that I never used the word constitutional in my comments. That word was used by the Senator from Utah.

Senator HATCH. I agree with you. I just wanted to make the record clear myself. I knew you could not have meant that.

The CHAIRMAN. All right. Let me intervene here. Senator Riegle, if you would go ahead.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN

Senator RIEGLE. Thank you, Mr. Chairman. And let me thank you and Senator Mitchell, both, for your important leadership on this issue. As Senator Mitchell said, the four of us have drafted a health care proposal.

He and I, Senator Rockefeller, and Senator Kennedy have a bill that deals with the issue of cost control and making sure that everybody in America has a chance to have health insurance coverage.

This is an urgent issue. I am convinced that if the top leaders of our government from the President on down lost their health insurance coverage today and did not have it, that within a matter of hours there would be a plan on the table to restore health insurance coverage for the top officials of our government.

The President has not sent us a specific legislative proposal on health care, and I think that is an inexcusable failure of leadership because this is an urgent problem.

In my home State of Michigan alone we have got fully 1 million people without health insurance at all, 300,000 of which are children. To have that situation go on day after day is not only inhuman, in my view, but I think it really hurts our economic performance, it hurts our economic future.

And the soaring cost of health care coverage for those who do have policies are crushing families, they are crushing businesses, they are crushing hospitals.

Virtually everybody that is involved in the health care system says the situation is out of control. We are spending over $800 billion a year.

We are spending more as a percentage of Gross National Product than any other country, and yet we have 40 million people with no insurance, and the rest that have it are finding that they cannot afford it or that the coverage is being whittled down day by day.

We ought to enact a plan this year, and I hope we can press ahead as a committee. I will be having hearings in our subcommittee on the particular aspects of the health insurance issue. But this is something the American people want done, it is something that must be done, and I hope we will enact legislation this year. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator. Well, we are pleased to have the Director of the Congressional Budget Office, Robert Reischauer. Mr. Reischauer, if you would proceed.

STATEMENT OF HON. ROBERT D. REISCHAUER, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. REISCHAUER. Mr. Chairman, Mr. Leader, members of the committee, I appreciate the opportunity to appear before you today to discuss possible approaches to health care reform and their potential for controlling costs.

With your permission, I am going to submit my prepared statement for the record, and I will summarize that statement.

The CHAIRMAN. That will be fine.

[The prepared statement of Mr. Reischauer appears in the appendix.]

Dr. REISCHAUER. The Nation faces two major health-related problems. The first is that a large and growing number of Americans lack health insurance coverage. The second is that health care expenditures are very high and are rising at a virtually unconstrained rate.

Those problems, of course, are feeding on each other. Rising health care costs lead to increased insurance premiums, and that, in turn, increase the number of individuals without insurance.

Many bills have been introduced to address these problems. The comprehensive proposals tend to follow one of three general approaches.

The first approach encompasses the proposals that offer tax subsidies to help the uninsured and low- and moderate-income people purchase private health insurance. Those proposals usually include further regulations to ensure that insurance is both available and affordable to individuals and small businesses.

The second approach encompasses the play-or-pay plans that require employers to offer health insurance to their employees or to pay a tax to help offset the cost of a public insurance plan that would be made available to those who do not have employment-based insurance or some other coverage.

The final approach encompasses the proposals that would replace the existing health care system with a single-payer public plan covering everybody.

Proposals that fall under any of those three general approaches could significantly expand access to health insurance and improve the continuity of insurance coverage. They would also affect the degree of choice available to consumers, the level of national and Federal health expenditures, and the potential for controlling health care costs.

The impacts of any reforms on these dimensions will depend importantly on the details of the specific proposal. Page 6 of my pre-

pared statement contains a table that provides some estimates of the effects the illustrative examples of each approach might have.

For example, it suggests that a tax subsidy plan like that of the President would cut the number of uninsured roughly in half; boost national health expenditures by about 2 percent; and increase net health spending—including the change in tax expenditures—at the Federal level by about 15 percent.

The illustrative pay-or-play plan shown in that table would reduce the ranks of the uninsured by about two-thirds, but national health expenditures would rise by 3 percent and Federal health expenditures by about 15 percent.

The example of a public insurance plan that is shown in the table would have little effect on overall spending, even though it would cover everyone in the country. However, net Federal spending on health would initially increase by more than one-third; private spending on insurance and health care would fall; consumer choice would be reduced significantly; and there would be a good deal of redistribution among both consumers and providers.

Effective cost containment can be incorporated into any of these three approaches, but it could be achieved most directly under a government-run, single-payer plan. However, I do not want to leave you with the impression that a single-payer system of this sort would guarantee effective control of health care expenditures. The extent to which spending was constrained would depend entirely on the decisions that were made about prices, the use of services, cost sharing by patients, and the amount and distribution of capital and new technology. Those decisions would have to be made by our political authorities, and they would not be easy to make.

Health care costs can also be controlled under other systems, including the existing one—as it stands or augmented by either a tax subsidy of the President's form or a play-or-pay mandate. To be effective, however, the cost control mechanisms for these systems are likely to prove just as difficult, complex, and intrusive as those implied by a single-payer system.

Over the past two decades, both public and private payers have made concentrated and concerted efforts to apply many kinds of cost control strategies to the current health care system. The evidence does not suggest that we have been tremendously successful on this front.

Let me summarize some of the lessons we have learned over this period. First, strategies that raise the out-of-pocket costs of health care for consumers through increased cost sharing have limited effectiveness—because consumers do not appear to be particularly sensitive to changes in their out-of-pocket costs. The major reason for that is the consumer's lack of knowledge about alternative treatments, their costs, their efficacy, and the consumer's resulting inclination to delegate decisionmaking to physicians and other providers.

Second, although managed care and controls on the use of services can reduce costs, substantial savings are likely to be realized only through fully integrated health maintenance organizations that have their own delivery systems. And the number of Americans who prefer this form of health care seems to be limited.

Third, price controls can be effective in reducing both the level and the rate of growth of spending; but their impact is partially offset by the tendency of providers to increase the volume of services to recover their lost revenues.

In addition, limiting the tax exclusion for the share of health insurance premiums that employers pay could reduce health spending by inducing employers and employees to change the provisions of their insurance policies. That, in turn, could cause consumers to be more cost-conscious in their use of services. But, of course, policy proposals along those lines have been rejected repeatedly over the course of the last decade.

Other ways to control costs include expenditure limits, that is, prospective budgets for hospitals; expenditure targets for physicians; and caps on overall national spending. While such limits could substantially reduce the rate of increase in health spending they would involve major changes in the existing health care system. Furthermore, to be effective, expenditure limits must be applied comprehensively. Otherwise, providers could increase prices and the volume of services for unaffected groups in order to maintain their revenues.

The CHAIRMAN. Sir, if you would summarize your comments.

Dr. REISCHAUER. All right.

The CHAIRMAN. We have had your testimony and have had a chance to get into it. We will have it submitted for the record. If you would summarize it, then we will get to the questions, please.

Dr. REISCHAUER. All right. All of the cost control strategies that I have just mentioned are contained in one or another of the legislative proposals that are before the Congress. As a result, the Congressional Budget Office (CBO) is required to provide estimates of those cost containment strategies and how effective they would be.

In so doing, I should emphasize we take into account that providers can increase volume in order to recover lost revenues—and can increase prices if their volumes are restricted. We also take into consideration the fact that policies extending to all consumers and payers are likely to have a greater effect than those imposed on just part of the market. And we include in our estimates the realization that the various voluntary types of restraints are likely to prove rather ineffective unless they are also accompanied by very strong incentives.

Let me leave you with a bottom line, which is an unfortunate one but nonetheless true. Effective control over costs will probably require rather extensive government involvement in our private health-care markets; and that intervention will adversely affect some aspects of our current system that we all regard as desirable. That is the unfortunate set of tradeoffs we are going to face over the next few years as we try to reform the system to improve access while limiting Federal expenditures and private expenditures. Thank you, Mr. Chairman.

The CHAIRMAN. Well, you lead me to a question right there, then. Give me a couple of examples of how you think it would adversely affect, as you stated, some of those things that we value in the present system?

Dr. REISCHAUER. Right now we have a tremendous amount of choice as consumers.

The CHAIRMAN. Choice one of them. All right.

Dr. REISCHAUER. We have a choice over the insurance policy we have, over the providers that we choose to go to, and over alternative treatments.

The CHAIRMAN. Right.

Dr. REISCHAUER. It is likely that choice would have to be restrained.

The CHAIRMAN. That is a major one. All right. What is your second one?

Dr. REISCHAUER. The second one would be that the pace at which new technology is developed and disseminated would probably have to slow down.

The CHAIRMAN. Well, those are meritorious concerns. Now, let me ask you to give me a little more detail on the tax subsidy approach, or play-or-pay.

There are still some individuals, as I look at this table in your statement who would be uninsured. On the tax subsidy, you say 5 to 7 percent, and on pay-or-play, 1 to 3 percent. Who are these individuals, and how would they ultimately be covered?

Dr. REISCHAUER. Under the tax subsidy approach—and the illustration is the President's proposal—there would be currently uncovered individuals who, when offered a tax subsidy or a tax deduction, would not regard that as a sufficient incentive to purchase private insurance because the subsidy was so small relative to the cost of insurance.

Insurance is extremely expensive, as you know. We are talking about $3,500, $4,000 for a family. And a family that had an income above the tax entry point—let us say 145 percent of the entry point—would be receiving a relatively small tax subsidy relative to the cost of insurance. If the members of that family felt they were healthy, or if they had other pressing needs, they might decide not to purchase insurance. As you know, there are people with relatively high incomes in this country right now who choose not to buy health insurance.

The CHAIRMAN. Well, let us get to the question, then, of on a single-payer system. You said the results there would vary some to the extent that private health insurance was brought into it. Can you give me some examples as to how that has worked or not worked in other countries?

Dr. REISCHAUER. The issue here is the extent to which you allow private insurance to develop, to pick up either the payments or services, not fully covered by public insurance. A prime example would be the Medigap policies that we have in this country. To the extent that those policies exist, they reduce the consumer's sensitivity to prices and lead to larger overall expenditures.

The particular single-payer plan we costed out would preclude any types of insurance that covered the deductibles or coinsurance on covered items; in other words, private health insurance could only cover services that were not covered by the public plan. And the public plan in our illustrative example is a relatively basic one. It would leave such services as dental care and eye care out of the equation, so the consumer might buy a supplemental policy to cover those.

By and large, supplementary insurance plays a very limited role in other countries. There is some in the Canadian system, I know.

The CHAIRMAN. Well, then, tell me this. The single-payer approach, as I understand it, you tell me would not increase the costs of national health spending. Let me put it that way.

Dr. REISCHAUER. Yes. That is the particular variant we costed out.

The CHAIRMAN. All right. But, then why would the other approaches add 2 to 3 percent to increased spending? Why would that not happen under the single-payer?

Dr. REISCHAUER. It does not happen in the single-payer plan that we costed out because, first, we applied basically the Medicare reimbursement to all insurance methodology, with some adjustments, for hospital services and physician services. Of course, Medicare rates tend to be below what private insurance is now paying, so there would be a reduction in costs. The provider serving people now covered by private insurance policies would be reimbursed at lower rates.

Second, we have built some administrative savings, although the ones in this calculation are a lot smaller than those you have read about in other studies.

The CHAIRMAN. Thank you. Senator Packwood.

Senator PACKWOOD. Dr. Reischauer, about a year ago you testified before this committee. Correct me if I am wrong, but you indicated, absent any change of law, in your judgment, total health care expenditures in this country would go from 13 to about 20 percent of GNP. And I cannot remember if you said by 1996, or the turn of the century.

Dr. REISCHAUER. It was 20 percent of the Federal budget, I think, by 1997. We are just completing a baseline set of estimates on where we think national health spending will go if there are no reforms to the system. It will be an alternative set of projections to those that the Health Care Financing Administration (HCFA) has produced. And it should be ready within a month or two.

Senator PACKWOOD. I am not trying to criticize or cross examine you.

Dr. REISCHAUER. I understand.

Senator PACKWOOD. But I could swear you talked about GNP and not a percent of the Federal budget. I can go back and get it. I thought it was GNP.

Dr. REISCHAUER. I might have. But if I did at that time, I was simply repeating the estimates that HCFA had put out.

Senator PACKWOOD. All right. Now, let me ask you another. On single payer, when we go home, the bill that the single-payer advocates are pushing is the Russo bill, and that is the one they mention all the time.

And, in his bill, he wipes out all health insurance. And he assumes that all medical expenses are going to be paid by the Federal Government. He uses the Canadian example and he says you will never see a bill when you go to the doctor's office, and the government is billed.

And, therefore, you have no private health expenditures in this country. They are all going to be government, and they are all going to be Federal Government.

Health spending in the United States last year was $809 billion, I think, not counting long-term care. I may be off on that.

Dr. REISCHAUER. I think that counts everything, including government research.

Senator PACKWOOD. Yes, that is correct. Although the research is a relatively modest part of that whole figure. But the Russo bill would have all of that transferred to the Federal Government, if I read his bill correctly.

Given that, because when you mentioned a single-payer system and an increase of about 34 percent in costs, that is the Federal Government's cost going from roughly, as I figured, about $210 or $220 to maybe $310 or $330.

But if you are talking about the Russo bill, you are talking about the Federal share going to the $809 billion, and paying for everything from dollar one, and presuming no increase in utilization.

If that is the bill we are going to on single-payer, then would you have any suggestions as to how that would conceivably be financed?

I realize employers are no longer going to pay health insurance, and the States will not have obligations that they now have. But the Federal Government would have a whale of an obligation. As I figure, it would take about a 28-percent payroll tax, if we did it by a payroll tax.

Dr. REISCHAUER. Obviously, with a plan such as the one you have just described, we would either have to substantially reduce spending on other government programs, or substantially raise government revenues. CBO has not analyzed the Russo plan in any detail.

I would just add that I think there are few, if any, countries in which all health care spending goes through the public sector. In the Canadian system, I believe, individuals are responsible for prescription drugs, and if they want a private room, they have to pay extra. Various out-of-pocket expenses are part of the system. Some of the Canadian provinces have been lobbying to include some coinsurance in their plans.

Senator PACKWOOD. Well, the reason, Doctor, I emphasize this, is I do not want to go out of here and say, well, gee. I heard Dr. Reischauer say that we could go to a single-payer system and the increase would only be 34 percent of the Federal cost. You very clearly qualified that in your statement about how much of that is going to be picked up by private insurance.

But I am taking the Russo bill, because I have spent enough time with it now to know what he is advocating, and he means a total Federal take-over of all health expenditures in this country, public and private, including State expenditures.

In which case, you are talking about an immense increase in Federal spending. I realize that it will be offset by other spending, but, in that case, I simply want to know who is going to pay for that increase in Federal spending.

Is it a payroll tax of 28 percent, is it an increase in the corporate tax? And I did not want anybody to take your statement away and say, well, he says we can do a single-payer system for infinitely less. It is a question of what you put in the system.

Dr. REISCHAUER. That is quite true. I also pointed out that in the system we have costed out here, there would not only be some things covered out-of-pocket with coinsurance and deductibles and some not covered at all, there would also be a substantial reduction in the revenue stream for some providers.

Senator PACKWOOD. All right. I thank the Chair.

The CHAIRMAN. Thank you. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you. Bob, I would ask you just one basic question. I talked yesterday with Nancy Johnson, from Connecticut, and I think you have had experience with her at Ways and Means, talking about how to estimate savings.

And I think one of the great frustrations we all have around here is we get debited for the amounts we spend and we do not get credited for the amount that that spending will save.

And if we try to go down sort of a productivity improvement route, whether it is within Health America, or it is within a single-payer system, or it is within another kind of a system.

And we try to get rid of a lot of insurance companies, we try to go towards community rating, we try to do Alain Enthoven's program, or something like that. We end up in some way coordinating or managing care and reducing costs from it.

We need a little help, a little encouragement from the estimating system. As I recall, Nancy had encouraged you to either take a look at a community or to take a look at some group of HMO's where they were involved, or not necessarily just the HMO's.

How have you approached that issue, and would you mind sharing with us what you experience as some of your potential difficulties, and, hopefully, some opportunities?

Dr. REISCHAUER. The real problem here is one of comprehensiveness. The record of the last 15 or so years has shown that we can put controls or incentives on one part of the health care market. Those controls can appear to be quite effective for a firm or a specific group of patients. But, the health care market is like a balloon: when costs are squeezed in one area, they pop out somewhere else. The providers have an ability to respond to the constraints that are placed on them. Therefore, unless the incentives or constraints are comprehensive, unless they cover more or less the whole marketplace, they are likely to be rather ineffective.

We are continually faced with the problem of an individual member or a committee saying, look at XYZ Company and how effective it has been at holding down medical costs. At the same time, in the metropolitan area in which XYZ is located, costs have been going up at exactly the same rate as before. We have a wonderful example from Federal experience during the 1980's. During the last half of the 1980's, we rather successfully held down the rate of growth of Medicare spending.

Senator DURENBERGER. Right.

Dr. REISCHAUER. At the same time, national health expenditures rose a little faster—if anything—than they had risen in the first half of the 1980's. In other words, whatever success was achieved from a Federal budgetary standpoint was, in a sense, taken out of the pockets of people who paid premiums for private insurance.

Senator DURENBERGER. Yes. And I share that. I mean, we have controlled the hospital costs with DRG's, and all the business went out-patient, and the price went up.

I also share with you the notion that this is an all-or-nothing proposition. You do it all. If you stop half way, the market will kill you. I mean, that is the wonderful thing about a marketplace that will always find some way to make it if, in fact, you do not make it appropriately function.

But, within your own response, you gave us samples of the sort of sub-cultures, if you will, where following a certain set of courses you do end up with savings.

Dr. REISCHAUER. Yes.

Senator DURENBERGER. You could come to certain companies, you can go into certain communities in this country where they followed a certain set of more comprehensive principles.

Dr. REISCHAUER. But we have to keep our eye on another thing: whether we are producing a once-and-for-all drop in spending or affecting the rate of growth of spending.

Senator DURENBERGER. Perfect. Right.

Dr. REISCHAUER. Many of these control measures are somewhat effective at ratcheting down spending by 6 percent, 3 percent, whatever.

Senator DURENBERGER. Right.

Dr. REISCHAUER. But they do not do much to affect the rate of growth of spending. So, it is a little like saying, we will just ignore the next 4 months worth of increases in health care costs. But, we will essentially be right where we would have been in the year 2000.

Senator DURENBERGER. Yes. And that is such an important distinction, because so much of the debate ignores the distinction between what you might call dynamic productivity which gets better, and better, and better all the time in terms of improving quality and cost reduction, and sort of static, which is the one-time saving of going to a uniform billing system or something like that.

The CHAIRMAN. Thank you. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Doctor, I think it is clear that the United States spends more per capita than any other nation on health care.

Also, I think it is true that all industrial nations, regardless of their system of health care payments, are experiencing very steep increases in costs.

I have before me—and I do not know whether you have done any separate studies on this—a chart put out by the OECD.

And the comparison shows that between 1970 and 1989, health care expenditures in Canada, which, of course, has a single-payer system, went up at an average of 12.2 percent per year. Over that same period, the United States went up 11.7 percent per year.

Now, we have heard a good deal about the single-payer system, but this would seem to indicate that it does not, by itself, guarantee a restraint on growth in spending.

True, the Canadian system starts at a lower base per capita expenditure. But my point is that Canada, with its single-payer system, has gone up at a greater rate of increase per capita than the

United States. Do you have any comments on that? Have you done any separate studies?

Dr. REISCHAUER. I agree with you completely that, as I said in my oral statement, what controls the rate of growth of costs in any system is a set of very difficult decisions that have to be made in several areas: the prices that are going to be paid the providers, the utilization of services, the rate at which we are going to allow technology to improve, and the rate at which we are going to distribute that technology. Right now we have basically an unconstrained system. You could also have a single-payer plan that was relatively unconstrained.

In a single-payer system, particularly, these are political decisions. The government would have to decide how fast these changes that increase costs were going to be allowed to occur.

Senator CHAFEE. Well, I think that is very important testimony, because some suggest that somehow we could have more for less, and the charts do not indicate that.

Do you agree with the assessment that not only are there no simple solutions, but socioeconomic concerns such as poverty, or alcoholism, or substance abuse, or even the prevalence of gunshot wounds can affect these statistics, regardless of how the health care system is structured?

Dr. REISCHAUER. I agree. It certainly has been argued that the lifestyle of Americans causes their health expenditures to be higher than those of certain other countries.

Senator CHAFEE. Now, I am not sure that I understood your answer to Senator Packwood. If you look at your chart, you will see that the Federal Government expenditures go up 34 percent under the single-payer public plan.

But you did not indicate how that would be payed for. The money has got to come out of taxes somewhere, i.e., taxes on individuals or business. Am I correct in that?

Dr. REISCHAUER. Not quite correct, because over the last decade we found a third way—increased deficits. [Laughter.]

Senator CHAFEE. Well, all right. That has a lot of appeal in the Senate. [Laughter.]

Dr. REISCHAUER. Not to me or my children.

Senator CHAFEE. Well, I do not believe it appeals to any of your children. Let me ask you a quick question. If you assume cost sharing requirements under a single-payer approach, have you made any adjustments for increases in utilization in your calculations?

Dr. REISCHAUER. CBO does have cost sharing in this plan, so that was not part of this estimate. We do have a methodology that would increase utilization if there were no cost sharing.

Senator CHAFEE. I see.

Dr. REISCHAUER. So, if we were asked to price out a plan that had no cost sharing in it, we would have a higher set of numbers.

Senator CHAFEE. In your single-payer plan you assume cost sharing?

Dr. REISCHAUER. Yes.

Senator CHAFEE. Thank you.

The CHAIRMAN. Thank you, Senator Chafee.

Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. I would like to comment on Senator Chafee's point about a single payer system, implying that we can't have more health care without spending more money.

I would just like to explore that, and suggest that that is not true. Let me just explore that for a moment, playing Devil's Advocate here.

I would suggest that under a single-payer system we can have more for less. Because of much lower administrative costs.

And there has been no talk, so far, about the hassle factor that patients go through with hassling from their doctors, or the hospital, or the hassle factor that doctors go through with Medicare and HCFA, the intermediary, or whatnot.

And there is the GAO study that says there are dramatic administrative savings under a single-payer system.

I am just pointing out that under a single-payer system, theoretically there would be significant savings with reduction of administrative costs.

Dr. REISCHAUER. I think there would be administrative savings in the tens of billions of dollars. I do not think they would be anywhere close to $100 billion.

Senator BAUCUS. GAO said about $60–$70 billion. You are saying tens of billions, but not hundreds of billions.

Dr. REISCHAUER. Yes.

Senator BAUCUS. All right. Second, is it not true we get a little more for less in the sense that under a single-payer system with global budgeting, for hospitals and other providers, that we would cut down on a lot of duplicative and unnecessary capital equipment.

I am talking about the next generation of high-tech diagnostic equipment; for example, PET scans. And we have got our CAT scans, we have got our MRI's, and so forth. There are some who suggest that there is little clinical value in PET scans. I mean, there is some research value, but little clinical value. Those things cost several million dollars, and each hospital has got to keep up with the Jones' and have its PET scan now, and so forth.

I mean, under a single-payer system with global budgeting, there would be a way to reduce costs in the sense that it would cut down on the unnecessary equipment, at least doctors I talk to tell me, that really is not needed in a lot of cases.

But they order it because it is there and their patients want it, and it is easier for a doctor to say, all right, fill out a form and order the test than it is to go the patient and say, we really do not need it, and so forth. So, is there not a savings there?

Dr. REISCHAUER. There could be savings in that area, but those same savings could be realized right now under controls on the diffusion of capital-intensive technology.

Senator BAUCUS. But they do not exist today, do they?

Dr. REISCHAUER. They do not exist.

Senator BAUCUS. I guess what I am really getting at is, even though it is true in answer to Senator Chafee or Senator Durenberger's question that there may or may not be savings under a single-payer system of some kind—not necessarily Congressman Russo's system, but, on the other hand, certainly compared to the

present system—it is theoretically much easier to get control on costs because under a single-payer system there is an entity, the single-payer, whether it is public or private, making the decisions up front as to what the expenditures will be.

Dr. REISCHAUER. Yes. That is what I said in my testimony. I think that is correct.

Senator BAUCUS. Well, do you not think, as a general principle, it makes sense for us to try to find some system which does provide more assurance of reasonable cost controls, and also more accountability so we know who it is who is making these decisions.

Dr. REISCHAUER. Are you asking if it makes sense to endorse a single-payer system?

Senator BAUCUS. Well, I am not necessarily saying a single-payer.

Dr. REISCHAUER. We have to consider the tradeoffs that the Chairman raised: limiting consumer choice, limiting a number of desirable aspects of the existing system.

Senator BAUCUS. Well, let me get at that a minute. Are we really limiting consumer choice? For example, in some countries, in Canada I know this is the case, the patient can choose whatever doctor he wants. And it is fee-for-service, too. But the patient can choose whatever doctor he wants.

Now, it is true that there is dramatic reduction in insurance. But, to play Devil's Advocate, one could ask, what is the need for insurance under a system where, when you are sick, you walk into the doctor's office, you walk in the hospital, the doctor or hospital bills the appropriate single-payer and the bill is paid. There is no need for insurance. So, it sort of begs the question of——

Dr. REISCHAUER. But in a lot of these systems where you can choose your primary care physician, he or she is a gatekeeper who determines where you can go after that.

Senator BAUCUS. That is correct.

Dr. REISCHAUER. In the U.S. system, I can decide I have something wrong with me and go to a doctor——

Senator BAUCUS. I see my time is up. I appreciate that. I understand that and I agree with you, but my time is up. But the basic point is this.

Dr. REISCHAUER. Your time is up. [Laughter.]

Senator BAUCUS. This is the basic point. Then my time is up.

Dr. REISCHAUER. I think my time was up.

Senator BAUCUS. Well, the Chairman is looking at me. I think mine is about up, too. [Laughter.]

But, essentially, with the Chairman's indulgence here, even though there is a limit on choice, does the question not ultimately come down to, is there too much choice? And does it not make sense that ultimately we need a system where, in exchange for more assured high quality health care, we are probably, as Americans, going to have to have a trade off of a little less choice?

Dr. REISCHAUER. That is correct.

The CHAIRMAN. Dr. Reischauer, we would be delighted to take your statement for the record.

Dr. REISCHAUER. Thank you.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I would like to get some reason for the difference of opinion between you and a study by the Urban Institute.

You make clear in your statement that if pay-or-play is passed, employers who do not now offer health insurance might if there is some additional regulation.

The Urban Institute did a study for the Labor Department. It concluded that large numbers of workers now covered by employer insurance might be shifted into the State-level public system if play-or-pay were implemented.

So, could you comment on if there is an honest difference in opinion here and what it is attributable to?

Dr. REISCHAUER. I am not sure how much of a difference there is. We are in the process of examining that. What I want to make clear to everyone here is that these are particular examples of the three approaches. They are not identical to bills now before the Congress. The play-or-pay proposal in table 1 provides a much less generous plan than the Majority Leader's bill. The illustration is based on a fairly bare-bones plan. So, that plan would certainly be less attractive to many employers who now offer insurance.

It is also clear that the Urban Institute used a different data source than did CBO to make its estimate. We really do not have very good data for analyzing play-or-pay plans. Everybody responsible for doing so is patching together various pieces of information to come up with their estimates.

What we are trying to do is compare the effect of the Urban Institute's data base to the one we are using and see how much of the difference between our conclusions is attributable solely to different data bases—both of which are undoubtedly wrong.

Senator GRASSLEY. Well, when you get that done, highlight it for me, would you?

Dr. REISCHAUER. I would be glad to.

Senator GRASSLEY. Because I do not want to miss it. This is a pretty basic question that has to be answered.

Dr. REISCHAUER. Right.

Senator GRASSLEY. I would like to turn to another question about expenditure limits. Apart from the obvious consequence that we would hold down spending for health care, what other primary consequences for health care systems would there be if we were to adopt State-wide expenditure limits?

I am particularly curious about what will happen if we restrict what providers get for providing services by expenditure limits, but do nothing to control their input cost. Will the results be similar to what rent controls do for the deterioration of housing. Is there going to be a reduction of quality?

Dr. REISCHAUER. I think the answer is, it is inevitable that technological progress would not proceed as rapidly, and there would be a slower diffusion of new techniques. You might question whether that necessarily correlates perfectly with quality.

Right now, we develop new machines and new techniques but only years later—if then—do we examine them and decide whether they are really producing better results. And we rarely make a second calculation: are the better results worth the additional costs associated with them?

So, I think it is very difficult to judge the extent to which true quality would be reduced under a strict system of controls compared with our existing system. But I think the direction of change is as you have suggested—although your other witnesses might disagree with that.

Senator GRASSLEY. Well, in the first sentence of your response, you do see a correlation between quality and technology. Is that not what you were saying?

Dr. REISCHAUER. Yes. I would not argue with that.

Senator GRASSLEY. So, if you are going to have less technology, you are going to have less quality. I think you concluded that. Right?

Dr. REISCHAUER. But there is also a question of what we do about negative advances, that is, changes we make in the belief that we are moving forward and then discover—10 years later—that that was not really the case.

Senator GRASSLEY. All right. Thank you, Mr. Chairman. I might have a question I want to submit in writing.

The CHAIRMAN. Yes, of course.

[The questions appear in the appendix.]

Senator MITCHELL. Dr. Reischauer, table 1 of your testimony is entitled, "A Comparison of Estimated Effects of Illustrative Ways to Increase Insurance Coverage." You have stated in response to questions that those were illustrative and did not represent an effort by you to analyze specific legislation. Is that correct?

Dr. REISCHAUER. That is correct.

Senator MITCHELL. Indeed, at page 4 of your statement, you said, "The impact of any proposal would depend on the details of the proposal."

And with respect to play-or-pay, you identified three such factors as the contribution rate required of employers and employees to participate in a public plan, the treatment of part-time workers, and new regulations of the small group insurance market. Is that correct?

Dr. REISCHAUER. Yes.

Senator MITCHELL. And at page 12 of your testimony, you set forth the assumptions with respect to this illustrative model, and two of those three assumptions are different from the provisions of S. 1227, the legislation which I have introduced. Is that correct?

Dr. REISCHAUER. That is correct.

Senator MITCHELL. All right. So, this does not purport to be an analysis of that legislation. Is that correct?

Dr. REISCHAUER. Yes. I thought I made that very clear. In no way was it an analysis of legislation.

Senator MITCHELL. Right. Now, it is unclear on its face, and unclear to me, how you arrived at some of the figures in the table. It is complex, so I am not going to ask you to respond orally now. But I ask you to submit in writing, if it is not otherwise covered in detail in your statement, particularly with respect to the category on the table entitled, "Initial Percentage Change in Spending for Health."

You have, under Tax Subsidies and Market Reforms, a 2-percent increase nationwide, Federal Government outlay increases of 8 percent, and tax expenditure increases of 39 percent.

In the next column under play-or-pay, you have for the same three categories 3 percent, 17 percent, and 9 percent. And, yet, in both of them you have an identical total of 15 percent.

And I wish you would explain to us how those three completely different sets of numbers could produce precisely the same increase in total health expenditures.

There may well be, and there probably is, an obvious explanation. But it is not obvious on its face. And I wish you would submit to us a detailed statement in that regard.

Dr. REISCHAUER. I would be glad to.

[The answers appear in the appendix.]

Dr. REISCHAUER. The total health expenditure numbers of 15 percent are total health expenditures by the Federal Government. And, of course, outlays and tax expenditures under the baseline are of different size, and we are multiplying them by different percents. It happens that the results are equal. But, for the record, I will provide you with the explanation.

Senator MITCHELL. So, the nationwide increase of 2 and 3 percent is not relevant to the total of 15 percent.

Dr. REISCHAUER. Correct.

Senator MITCHELL. And what you are saying is that an outlay increase of eight percent and a tax expenditure increase of 39 percent produces the same result as 17 and 9 percent.

Dr. REISCHAUER. Correct.

Senator MITCHELL. Well, it will be interesting to see how that works out. Because I guess this proves what everybody has said, that this is a complex problem. [Laughter.]

Dr. REISCHAUER. Yes. Tax expenditures are relatively small compared with Federal outlays for health.

Senator MITCHELL. Yes. All right. Now, I would like to address the question posed by Senator Grassley when he referred to the Urban Institute study.

First, I think it should be clear for the record that the author of that study denounced the administration's use of the study as inconsistent with what the study actually said, and a distortion of the study's results. That should be on the record, because that was clear and publicly reported.

Now, it is true, is it not, that the number of employees who would be shifted to the public plan would depend upon a number of factors, and especially the rate at which the alternative payroll tax was set. Is that correct?

Dr. REISCHAUER. That is correct.

Senator MITCHELL. Right. And, therefore, anyone assuming a certain number of employees would be shifted, would necessarily have to first assume a certain level of payroll tax in order to make that calculation. Is that correct?

Dr. REISCHAUER. That is correct.

Senator MITCHELL. And is it not also correct that in the legislation that we have introduced, S. 1227, no specific payroll tax is set forth, but rather, that decision is left to the Secretary of Health and Human Services following a lengthy process of inquiry and evaluation to determine what the appropriate rate would be.

Dr. REISCHAUER. That is correct.

Senator MITCHELL. All right. Mr. Chairman, I have a number of other questions, but I see my time is up. I would like to submit them in writing to Dr. Reischauer.

The CHAIRMAN. Yes, of course. That will be done.

Senator MITCHELL. I look forward to your response on the table. Thank you, Dr. Reischauer.

[The questions appear in the appendix.]

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. And thank you, Dr. Reischauer, for being with us. It is a very detailed paper, and we appreciate your presenting it to us.

It seems to me that there is a great deal of misconception about health care, the issues, and the problem, and what causes the costs to be as high as they are among the general public, which makes our job much more difficult because there is no consensus to what even the problem is by the general public.

It is interesting, in the study that is going to be presented later on, that most Americans over-estimate greatly their own contribution to their health costs.

The study points out that many Americans believe that their out-of-pocket costs account for as much as 70–80 percent of their health costs that they have to bear, when the opposite is really true; that government and employers are picking up 70–80 percent and the individual is picking up somewhere between 20–30 percent.

And then, when you ask most Americans, what is the real reason for health care costs being as high as they are, the overwhelming majority of Americans think it is waste, and fraud, and abuse, sort of like the Ross Perot solution to everything: get rid of that, and you solve the problem.

It makes our job much more difficult, because there is a tremendous amount of confusion. It is interesting that the survey also indicates that many people are for national health insurance, they just want to keep the national government out of it.

So, we have got some real education to do with the general public, I think, in the sense of trying to get us on the same track. The point I want to raise with you, I have become more and more interested and concerned, really, about lack of discipline among consumers of health care services in this country.

I have the feeling that as more and more third parties pay for the cost of the services, either the employer, the government, Medicare, Medicaid, or insurance, that there is not a great deal of discipline in how individuals consume health care in this country. And you talked about it on page 20, I think.

And one of your thoughts, it seems, was strategies that would raise the out-of-pocket costs of health care for consumers are predicated on the assumption that consumers would be more cost-conscious if they paid more. I would like you to elaborate on that.

Are there studies or information out there that indicated that if consumers did bear more of a burden of the costs initially and up front, they would be better consumers, they would shop right for health services in this country?

Dr. REISCHAUER. The evidence—a lot of which comes from the health insurance experiments we have run over the course of the

last decade—indicates that consumers are relatively insensitive to price changes.

Senator BREAUX. Under the current system.

Dr. REISCHAUER. Under the current system. When consumers are faced with paying a higher portion of the bill, they generally avoid the initial visit to the doctor. But once they are in the doctor's hands, they tend to abrogate responsibility for making these decisions and instead take the advice of the expert, the doctor. In a sense, therefore, there is a reduction in the use of initial services when the price rises to the consumer but very little impact on secondary services. What that tends to do is cause low-income people, those under budget constraints, to avoid going to the doctor and perhaps avoid the preventive care that many of you are most concerned about their receiving.

There is also another simple issue here: it is terribly hard to know exactly what you are going to be charged for any particular medical service. In the first place, the provider by and large has very little idea what the visit, the tests, the procedures are all going to amount to. In the second place, the provider has very little idea what fraction of that is going to be paid by the patient's insurance.

So, unless you are something of a mathematician and an insurance expert, it is very difficult for you to know, when visiting the doctor or undergoing a certain procedure, exactly what price you are going to be faced with in the end. And that price, after all, affects your behavior.

Senator BREAUX. Let me ask a question. You mentioned in that same page about the use of flexible spending accounts.

Dr. REISCHAUER. Yes.

Senator BREAUX. What are your general thoughts, if you have any, on medical IRA type of approaches that would be employer contributions to an employee that he or she would use to pay, say, the first $2,000 of medical expenses, if that account would inure to the benefit of the patient if, in fact, all of it was not used?

Dr. REISCHAUER. Are you talking about flexible spending accounts in which individuals can reduce their salary, say, and provide a pool of resources that they can then use to defray out-of-pocket expenditures? I think, by and large, that increases health spending very significantly.

Senator BREAUX. We do not have the time. That is not the concept. We will have to talk about it. Maybe I can submit something in writing to you about it.

[The questions appear in the appendix.]

The CHAIRMAN. Thank you. Senator Danforth.

Senator Danforth. Dr. Reischauer, right now, according to your paper, there are some 33 percent of the American public that is uninsured.

Dr. REISCHAUER. Thirty-three million.

Senator DANFORTH. I am sorry; 33 million.

Dr. REISCHAUER. Yes. That was in 1989, which is the year of the data underlying these estimates.

Senator DANFORTH. All right. And then there were various proposals for covering those 33 million people. That is what we are talking about; what is the cost of covering them?

Now, what happens to these 33 million people right now if they do get sick? Do they just get sick and nobody does anything, or they do get treated, do they not?

Dr. REISCHAUER. They get some treatment. The more serious their problem, the more likely it is to be treated. But the evidence suggests that they use probably about half as many medical services as the insured population uses.

Use differs for doctor visits and hospital visits, but the effect is greater for hospital visits, many of which are of an emergency nature. And the expenditures that result are picked up by the rest of the population through higher taxes, higher premium payments, and other methods.

Senator DANFORTH. But if we were to cover them with insurance, there would be a net increase in the cost of health care in the country. Is that correct?

Dr. REISCHAUER. They would consume more health care than they do now, and we have included in our calculations a rough doubling of their consumption.

Senator DANFORTH. And that is what this chart indicates, that there is going to be more health care provided, and, therefore, the cost is going to be higher.

Dr. REISCHAUER. Correct.

Senator DANFORTH. And when you say the cost goes up nationwide 2 percent for a tax subsidy program, 3 percent nationwide for a play-or-pay program, that is all sources of paying for it, government and non-government. Is that right?

Dr. REISCHAUER. That is total national health expenditures——

Senator DANFORTH. Total national health.

Dr. REISCHAUER [continuing]. Would rise by about that amount.

Senator DANFORTH. All right.

Dr. REISCHAUER. That is for particular variants of these plans.

Senator DANFORTH. I understand that. But what you are saying now is that the total amount of gross national product that is consumed by health care, say, projected for, let us say, 1995, would be about what, do you know? I mean, without these charts, without universal coverage, just under the present system?

[Pause.]

Senator DANFORTH. Pick a year that you do know. Maybe this year.

Dr. REISCHAUER. The amount is about $700 billion this year.

Senator DANFORTH. Which would be what percent of GNP?

Dr. REISCHAUER. It is projected to be 14 percent this year. Of course, one reason is that the gross national product (GNP) has not grown very much during the past year.

Senator DANFORTH. All right. So, it is about 14 percent of GNP this year that is consumed by health care. And what you are saying is that if we move toward universal coverage, then that would be increased to what?

Dr. REISCHAUER. That depends on how one moves toward universal coverage. If you took the single-payer plan—the particular variant that is costed out on table 1—it would be unchanged.

Senator DANFORTH. All right.

Dr. REISCHAUER. I should add one other thing about table 1. These nationwide expenditure increases are increases before any major cost control effort went into effect.

Senator DANFORTH. I understand. All I am trying to do is to say it is my understanding of your point that if we move toward universal coverage, that costs us something.

Dr. REISCHAUER. If we move to it under the particular tax subsidy or play-or-pay variants that are in this table, it would cost us something.

Senator DANFORTH. All right. And what it would cost would be an increase of 2 to 3 percent in the cost of health care, and that would translate into some increased percentage of GNP spent on health care, would it not?

Dr. REISCHAUER. Right. But if we are spending $700 billion in the current year, a 2-percent increase would be $14 billion more.

Senator DANFORTH. $14 billion more. All right. Now, that is an annual increase. And, of course, every year it provides the base for future increases. It is compounded, correct?

Dr. REISCHAUER. Correct.

Senator DANFORTH. Yes. Now, I will just ask you one more question. Do you know of any case where market incentives or an effort to provide competition in health care has had the desired effect of reducing the cost of health care or holding the cost of health care down?

[Pause.]

Senator DANFORTH. I take it from your testimony that you are leery of using market incentive systems for the reason that the consumer of health care is going to depend more on his physician than on market incentives.

Dr. REISCHAUER. If the incentives were extremely powerful—for example, if everybody faced 50 percent coinsurance—one would get a substantial reduction in health care utilization. I have no question about that. I do question whether that would be desirable, whether the resulting reduction would eliminate the procedures you think are least essential.

Senator DANFORTH. Let me just ask you, is it——

The CHAIRMAN. Senator, if you would, wrap it up, because we have gone long beyond our time limit.

Senator DANFORTH. I will wrap it up. It is fair to say, is it not, that we are barking up the wrong tree if we are looking at market incentives as the way to keep the costs down?

Dr. REISCHAUER. Alain Enthoven, I think, would argue that we have not tried competition and that there are frameworks in which it could make a substantial impact on holding down costs. I think the jury is still out on that.

The CHAIRMAN. Thank you very much, gentlemen. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman. Dr. Reischauer, I have a new chart here that I want you to look at it. Now, for the first quarter of 1992, the CPI increased by 1 percent but the cost of prescription drugs, increased by 3 percent.

So, the drug companies are continuing to push their prices upward at a rate of three times the cost of inflation. There is no other country in the world, no other country, no exception, where the cost

of prescription drugs is rising at the same rate of inflation as in the United States.

Now, these are American-made drugs. They are sold overseas for 40, 50, 60 percent less than they are sold here. Do you have anyone looking at this issue, or do you have any recommendations to us for dealing with this issue?

Dr. REISCHAUER. We are not looking at that issue at this time.

Senator PRYOR. Well, the reason I think we should look at this issue is because 5 million elderly Americans today are having to choose between the food they purchase or the prescription drugs they purchase. For three out of four elderly Americans today, the number one out-of-pocket health costs is prescription drugs.

And there is no end in sight. Evidently, the market approach that I assume most of us would like to work is not working. Do you agree that the market approach is not working in dealing with the cost of prescription drugs?

Dr. REISCHAUER. There is no question that there are problems. We could help make the market work better if we devoted more resources to evaluating the effectiveness of various drugs—as well as various other medical procedures—and then followed through with those evaluations and saw to it that insurance companies or the government refused to pay for the drugs that are less cost effective than others.

Senator PRYOR. All right. Do you have anyone in your office working on this question as to the effectiveness or lack of effectiveness—of the research and development tax breaks, or the section 936 tax break bonanza, or the cost/benefit ratios of all of these tax incentives we give to the drug industry to find the cure for cancer, AIDS, and other diseases? Is anyone looking at this?

Dr. REISCHAUER. No. We have a rather limited staff and a rather broad mandate.

Senator PRYOR. I am not trying to embarrass you, I am just trying to find out for myself.

Dr. REISCHAUER. I am not embarrassed.

Senator PRYOR. Fine. A moment ago, our good friend, Senator Chafee, asked a question relative to some comparative costs in the Canadian system. I would like to state that I am not necessarily an advocate of the Canadian system.

The Canadians, however, did something about prescription drug costs that I think we should all find of interest. The drug companies say that if the government does anything about containing drug prices, then they are not going to increase their spending on or do anything about research.

However, in 1987 the Canadians established a Price Review Board, and they forced the drug companies—our drug companies, mind you—to come before that board in Canada, and justify how much they are going to increase drug prices. Since that board was established, we have seen a 6-percent increase, 8-percent increase, 8.8-percent increase, 10-percent increase in 1996, in spending by manufactures in Canada for research on new drugs.

So, I think that the so-called board is not doing anything to deter further research by the drug companies, and I hope it is something that we may look at in the future.

I would only add—that I was somewhat surprised to see that now 73 percent of the American people, according to the Kaiser survey, now are supporting the government setting of the costs of the prices for prescription drugs.

And I might add that 69 percent Republicans say set the price; 77 percent of Democrats. So, I think that is enlightening by itself. Thank you, sir. Mr. Chairman, thank you.

[The prepared statement of Senator Pryor appears in the appendix.]

Dr. REISCHAUER. Thank you, sir.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Dr. Reischauer, I did not have an opportunity to hear your statement, but I appreciate very much the contribution you have made to the hearing. And, having looked through it, I can see that a good deal of very helpful research has gone into a comparison of the various proposals.

With deference, I would say, there is one kind of a plan that you may not have addressed, and I have not had a chance to look at it completely.

But some of us feel that there is a hybrid between play-or-pay and a single payer, which we call a State-based plan, that has a lot of the advantages that you see in both play-or-pay and single-payer plans.

And, so, I would hope that as we begin comparing the different models, a State-based plan also would be laid side-by-side with the other approaches that are being considered.

Prior to the question I want to ask with regard to the efficacy of the various models, I'd like to ask you, when it comes to cost containment, is there one mechanism that, in your view, is clearly the best for containing costs?

Dr. REISCHAUER. No, there is not. I think you are making a set of——

Senator DASCHLE. So, in terms of efficacy there is no advantage of one mechanism over another?

Dr. REISCHAUER. If the only dimension we were considering at is, could this procedure control costs?

Senator DASCHLE. That is what I am asking.

Dr. REISCHAUER. But there is a trade-off here.

Senator DASCHLE. Yes, I know, there are tradeoffs; obviously there are a lot of other considerations. But in the absence of any other consideration except efficacy in cost containment, what would you recommend as the most efficient cost containment mechanism?

Dr. REISCHAUER. I would not call it my recommendation. But certainly, if we had a uniform set of prices combined with utilization control, I believe that would prove to be the most effective.

Senator DASCHLE. Uniform set of prices combined with utilization——

Dr. REISCHAUER. Reviews.

Senator DASCHLE. So, I am still asking you which model?

Dr. REISCHAUER. That controls volume responses by providers.

Senator DASCHLE. Right. So, in other words, a global budget is probably the most effective way of containing costs. Is that right?

Dr. REISCHAUER. Well, that is not global budgeting.

Senator DASCHLE. I realize there are tradeoffs.

Dr. REISCHAUER. That is not global budgeting. And, in a sense, global budgeting and a lot of the mechanisms we are talking about are rather empty unless you say exactly how they would work.

Senator DASCHLE. Exactly.

Dr. REISCHAUER. And if you asked me, would global budgeting—giving each hospital only half of what it is spending now—be effective, the answer is, yes, it would be effective. Hospital expenditures would only be half of what they are now.

Senator DASCHLE. So, your answer is——

Dr. REISCHAUER. But we would be a very unhappy set of Americans as a result.

Senator DASCHLE. Are you unsure, then, which is the most efficient model in terms of cost control only?

Dr. REISCHAUER. What I am basically saying is I do not think it is a very interesting question to ask.

Senator DASCHLE. Well, I am sorry you do not find it interesting. [Laughter.]

I wish you would let me be the judge of that. But that was not a very interesting answer, frankly. [Laughter.]

Dr. REISCHAUER. It might have been interesting; it was not polite.

Senator DASCHLE. So, you choose not to answer it.

Dr. REISCHAUER. I choose not to answer that.

Senator DASCHLE. All right. That is an interesting comment for a witness who claims to be an expert. [Laughter.]

But, in any case, let me go on. When we talk about cost containment, another area that we really do not get into to my satisfaction is the issue of allocation. I do not think the only relevant question is how much we spend, it is what we spend it on that seems to drive so many of the costs.

Costs are influenced by several factors: paperwork; it is influenced by the fact that we access our system at the most expensive end of health care delivery; defensive medicine; overutilization, in some cases, of technology.

But, could you elaborate, to the extent you feel comfortable doing so, on allocation of resources and how that weighs into the overall cost equation?

Dr. REISCHAUER. I think most experts would agree that there is a misallocation of resources in at least these senses: that we have too many specialists and not enough primary-care physicians in this country and that Americans, as you say, after access the medical system at a more expensive level than need be.

I think it is also clear that we have an excessive amount of capital invested in this industry. I mean, we have too many MRI's, CAT scanners, empty hospital beds, and capital. We could run our system considerably more efficiently.

Because of our multi-payer, mixed public/private system, a tremendous amount of paperwork goes on in the insurance companies and in the doctors' offices. Substantial savings could be realized at that level as well.

Senator DASCHLE. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Gentlemen, we have gone far beyond what we anticipated timing-wise here in the questioning of Dr. Reischauer.

I know there are many other questions you would like to ask, but we also have some excellent witnesses that you can ask those questions of. Dr. Reischauer, we are very pleased to have you. Thank you very much.

Our next panel consists of Prof. Karen Davis, who is chairman of the department of health policy and management, School of Hygiene and Public Health, Johns Hopkins University; Professor Enthoven, who is with the Graduate School of Business, Stanford University, and is a professor of public and private management; Prof. Mark Pauly, who is chairman of the health care systems department, the Wharton School, University of Pennsylvania; Prof. Paul Starr, professor of sociology, Princeton University. Professor Davis, if you would proceed.

STATEMENT OF KAREN DAVIS, Ph.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF HYGIENE AND PUBLIC HEALTH, THE JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD

Professor DAVIS. Thank you, Mr. Chairman, and members of the committee. I would be happy to enter my statement for the record, and I would like to just highlight some points in the appendix of my statement in charts that are contained there.

The two major problems that we have talked about today that face the U.S. health care system are the absence of universal coverage and rising health care costs.

There are 34 million Americans who have no health insurance coverage. The majority of those uninsured Americans are working. Two-thirds are working full time; another 13 percent are working part time. Only 20 percent are out of the work force, either unemployed, early retirees, or people who are disabled and not yet covered by Medicare.

About half of the working uninsured work in small firms; are either self-employed or work in firms with fewer than 25 employees. Most of the uninsured are not, in fact, poor—only about 29 percent are poor—but they have modest incomes. Only about 40 percent have incomes over twice the poverty level.

However, even for Americans with insurance, inadequate benefits and limitations on coverage also can lead to high costs. Among people with individual insurance, they pay 40 percent of their health care expenses directly out-of-pocket. We have heard a lot today about the problem of health care costs. In 1990, we spent 12 percent of our GNP on health care.

My own estimates are, if we continue at historical rates, that will increase to 21 percent by the year 2000. On a per capita sense, we are spending about $2,700 per person in 1990 on health care.

By the year 2000, that will be $7,000 per person. That is not adjusted for inflation, so maybe by the year 2000 that will not seem like a lot. But I think you see the very dramatic increases.

As a percent of earnings of workers who are currently spending about 11 percent of workers' earnings on health benefits, that is projected to increase to 23 percent by the year 2000. We have heard today that the United States spends more on health care than any other country, at 12.4 percent of GDP, versus 9 percent for Canada and 8 percent for Germany.

On a per capita basis, Canada spends 43 percent less than the United States on health care; the U.S. spending is twice that of Germany; and, in Japan, it is 131 percent of the Japanese per capita expenditures.

That is, in large part, because other countries have a more systematic approach to cost control, a large role for government in setting prices, and overall budgets for health care.

It is also because administrative costs are substantially higher in our system. In individual insurance policies, administrative costs are 40 percent of benefits, compared with 1 percent in Canada of administrative costs as a percent of the total, or, in our own Medicare program, where administrative costs are only 2 percent of benefits.

As has been mentioned today, President Bush has proposed an outline but no legislative proposal yet to use tax credits and market reform.

As Dr. Reischauer pointed out, that is unlikely to provide universal health insurance coverage, nor will it guarantee adequate benefits because the tax credits and deductions that are in the President's plan are well below the average cost today of group health insurance for a family of $5,000.

There are three major comprehensive plans that have been proposed as alternatives. Employment-based coverage: I would split two types of public plans; one that I call a Medicare-for-all plan, which would take the current Medicare program, perhaps improve preventive services, but cover the entire population.

And what Dr. Reischauer described more closely resembles the Medicare-for-all, because his illustrative plan had cost-sharing deductibles.

The other type of public plan is a single-payer plan with comprehensive benefits, no cost-sharing, more on the Canadian model.

My own estimates are, if we were to stay with the current system, we would have about 60 percent of the population covered under employer-based plans, under an employed-based comprehensive reform, about 55 percent of U.S. population would be under private employer coverage.

The rest of the population would be covered under public plans, and, obviously, under the public plans, 100 percent of the population would receive their coverage.

I would like to focus a bit on Chart Seven in the appendix of my statement, which, unlike Dr. Reischauer's table 1, gives you a look over time.

Dr. Reischauer's table 1 is a static kind of first-year effect. It does not look at the effect of cost controls over time when you get cumulative savings.

We could reduce total spending in the year 2000 from $2 trillion to $1.6 trillion if we adopt a plan that phased in expenditure limits starting at GNP plus 4 percent, gradually reduce that to a rate of growth of GNP——

The CHAIRMAN. Let me interrupt. You said 7. Did you mean chart 17?

Professor DAVIS. Seventeen, yes.

The CHAIRMAN. Seventeen.

Professor DAVIS. Looking at projected national health expenditures out to the year 2000. If we had just phased-in cost controls on expenditure limits eventually tied to the rate of growth of GNP, we could reduce that to $1.6 trillion. Or, if we introduced limits tied to GNP immediately, we could hold it to $1.3 trillion.

Any of these three approaches—the Canadian-type plan, an employment-based plan—could achieve either modest or substantial savings of that amount so that total health spending by the year 2000 will be substantially less than it would be under our current system, and Federal spending would be even less under the employment-based option than under the current system. We would get substantial savings.

The CHAIRMAN. I am sorry to limit you this much, but we will get back to you and we will be probing on some of the statements.

Professor DAVIS. Surely.

The CHAIRMAN. You will get a further chance to make your points.

Professor DAVIS. Thank you. I would be happy to answer any questions.

[The prepared statement of Professor Davis appears in the appendix.]

The CHAIRMAN. Professor Enthoven.

STATEMENT OF ALAIN C. ENTHOVEN, Ph.D., MARRINER S. ECCLES PROFESSOR OF PUBLIC AND PRIVATE MANAGEMENT, GRADUATE SCHOOL OF BUSINESS, STANFORD UNIVERSITY, STANFORD, CA

Professor ENTHOVEN. Mr. Chairman, I would like to summarize briefly four key ideas and then I will submit my statement for the record.

The first, is that there is a great deal that can be done to improve health care quality and to cut costs drastically by appropriately motivated, comprehensive, integrated health care financing and delivery systems that cannot be done by the disorganized, traditional solo or single-specialty group, fee-for-service, third-party payment system that predominates today.

Integrated financing and delivery systems can do a lot to address many of the problems that have been addressed here, such as overcapitalized hospitals and under-capitalized ambulatory care facilities. There are too many specialists, not enough primary care, and the like. An integrated system of financing and delivery—hospital, doctor, and so forth—can attract the loyalty, commitment, and responsible participation of doctors and avoid the costly adversary relationship between doctors and payers created by fee-for-service; it can align the incentives of doctors and the interests of patients in high-quality comprehensive care; it can select the numbers and types of doctors that are needed for the population served and get the correct specialty balance; it can allocate resources efficiently across the total spectrum of care.

In brief, we have to get the basic organization and incentives right if we want to have an effective solution to our problems of health care cost, quality, and access.

Secondly, what we must do is to move forward as fast as we can to such a system, based on competing, publicly accountable inte-

grated health care systems with providers at risk for resource use so that they will be rewarded for finding and adopting less costly ways to care for patients.

To date, so-called competition of integrated financing and delivery systems has not ameliorated all of our cost problems because, basically, in this country we have not tried price competition.

There is a lot of misunderstanding and misinformation on this point, but the plain fact is that, with few exceptions, we have not tried price competition in this country.

Most employers structure their health benefit offerings in such a way that they contribute substantially more on behalf of people who choose the more costly rather than the less costly system, and the tax laws reinforce that.

At Stanford, if I were to belong to the most expensive of the plans we offer instead of to the HMO I chose, then the tax laws would be in there subsidizing, paying, in effect, 40 percent of the extra costs.

In other words, you could say demand is not very elastic, because if my HMO tries to cut price and pass that savings through to me, it gets filtered through the tax laws which greatly reduces the incentive for me to choose the economical plan.

Third, the small employment group market is not working. It is simply ridiculous ever to have thought that we could have a successful health insurance system based on small employment groups. These groups—I am thinking of groups less than 100—are too small to spread risk, to small to achieve economies of scale in administration, and too small to offer individual plan choice down at the individual level in order to create a competitive system.

As a model of how to do it right, I would offer the California Public Employees Retirement System, whose advisory council I Chair, where we provide health benefits to 800,000 people, both California State employees, retirees, and dependents, and also the employees, retirees, and dependents of about 800 other public agencies, including very small public employers.

We offer them a multiple choice that includes 21 HMO's and 5 PPO's. And we achieve great economies of scale in administration, we give all those people, including people in small employment groups, the efficiencies of being in a large and competitive employment group.

I refer to the idea as a health insurance purchasing cooperative and I think that if we had all small employment groups and self-employed buying through large competitive health insurance purchasing cooperatives we could greatly improve the efficiency and competitiveness of those arrangements.

Finally, if we were to do that, I believe we could see steps to universal health insurance, which I believe is a compelling necessity in this country to get everybody covered by a good quality health care program.

If we had health care purchasing cooperatives, then we could limit tax-free employer contributions to the price of the low-priced plan in the market area where each person lives so everybody could have tax-free the low-priced plan, but if they chose something that cost more, they would be required to pay the extra cost with their own money.

Then we could use those purchasing cooperatives as a vehicle for the public sector to sponsor the participation of otherwise unsponsored people into health insurance into the same choice of competing, private, organized health care systems that serves the rest of us. There, in brief, is a vision of a market-driven, competitive model of universal health insurance.

[The prepared statement of Professor Enthoven appears in the appendix.]

The CHAIRMAN. Professor Pauly.

STATEMENT OF MARK V. PAULY, Ph.D., BENDHEIM PROFESSOR AND CHAIRMAN, HEALTH CARE SYSTEMS DEPARTMENT, THE WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA

Professor PAULY. I am pleased, Mr. Chairman, to be able to discuss with the committee the impact of health reform proposals on the rate of growth of medical spending. Let me make a few summary points. No one would defend the growth rates produced by the current system, but the key question is how to lower the growth rates to appropriate levels, neither too high, nor too low.

There is, in my view, no painless way of doing this. I have an up-to-date dentist, and he always tells me what I think we need to tell the American people: this is going to pinch a little bit. And this is going to pinch a little bit.

Medical spending has been growing in excess of general inflation for two reasons. One, because the wages of people who work in the health care sector grows faster than wages and prices in general, and, second, because we adopt more costly but beneficial new technology.

I do not think that the United States, in contrast to some other countries sometimes presented as ideal models, will want to put the burden of cutting growth on raises for medical workers. That leaves the solution to the problem of cost growth dependent on our ability to control the form and the extent of the rate of growth of medical technology.

This simple proposition immediately disqualifies as remedies for long-term cost growth a number of popular suggestions. Cutting insurer administrative costs; raising consumer cost-sharing; pushing more people into HMO's; or using preventive care to improve health all may lower the level of medical spending, but there is no evidence and little conceptual reason to believe that they will lower the rate of growth in that spending year after year.

Cut costs by 10 percent, say, by using this year's favorite solution, single-payer, and save on administrative costs. That will help in 1993. If we implement it at that time, we would have a zero rate of growth.

But, if technology keeps doing what it has been doing by 1994, we would be back at double-digit levels. And administrative costs of insurance have nothing to do directly with the rate of growth of technology.

I believe that the most important thing for the government to do to cut the growth of medical spending is to stop doing something it does now that causes that growth to be excessive.

I am referring here to the current unlimited open-ended exclusion from income and payroll taxation of that portion of a worker's health insurance premium that the employer pays directly.

This inequitable and inefficient subsidy raises the cost of medical care by shielding consumers, whether directly or indirectly through the benefits managers of firms, from the true cost of the health insurance that they are buying.

An alternative solution, one that I think will continue to achieve the objectives of the tax exclusions but without the distortion is to replace the tax exclusion with a set of closed-end, refundable, fixed-dollar, tax subsidies toward the mandatory purchase of basic coverage.

Once you do that, once you make the price that faces buyers truly reflective of the cost of different health insurance plans they may purchase, then, supplemented with good information to buyers about the value of benefits and provided with advice from benefit specialists, employees and groups can be counted on to make reasonably good choices among health plans.

In such a setting, whatever the rate of growth of health spending turns out to be will be the right rate of growth. If buyers prefer plans that delay the introduction of costly technology because their premiums will grow less slowly, cost growth will be slowed.

If there are some costs and innovations that are so beneficial that buyers do not want to wait for them and are willing to pay higher premiums, then the rate of growth in spending will be higher, but that will be cause for cheer rather than concern.

It will still be the right rate of growth of cost, and one that permits different rates for different consumers, depending on how they value new medical advances compared to other things.

Along with some colleagues, I proposed a market-based reform program we call Responsible National Health Insurance. In contrast to the regressively financed play-or-pay schemes, our program is progressive in incidence, attentive to consumer choice, and replaces the open-ended tax exclusion with a system of tax credits that will benefit most Americans, even before medical cost savings are taken into account.

Regardless of which sort of reform one favors, one should obviously avoid throwing gasoline on a fire one is trying to extinguish.

A key ingredient in avoiding this action, and a key ingredient in any reform proposal, should be the removal of the loophole that powerfully stimulates inappropriate cost growth.

The CHAIRMAN. Thank you.

[The prepared statement of Professor Pauly appears in the appendix.]

The CHAIRMAN. Thank you.

Dr. Starr.

STATEMENT OF PAUL STARR, Ph.D., PROFESSOR OF SOCIOLOGY, PRINCETON UNIVERSITY, PRINCETON, NJ

Dr. STARR. Thank you, Mr. Chairman. I am one of those who supports national health insurance, not as a way to spend more money on health care, but because it will enable the Nation to spend less and to avoid many of the damaging economic side effects of our present health insurance system, including: job lock, which

prevents people from moving to other jobs where they could be more productive; welfare lock, which keeps people on welfare because the low paying jobs typically available to them do not carry any health benefits; and the increased strife between labor and management that now focuses on health benefits.

This morning we heard Dr. Reischauer talk about the incremental cost of universal coverage and whether it would be between zero and 3 percent of current health expenditures. But, of course, each year our health expenditures are rising far faster than that.

I think that only underlines, really, the central reality here, that a universal health insurance program can be far more important as a way of gaining leverage over the health care system and changing its underlying incentives and organization, and that this factor far outweighs the additional costs entailed by covering the uninsured.

I think the argument for moving out of an employment-based health insurance system to a citizenship-based insurance system has been blocked by the perception that if we did so, we would have to move to a federally-financed, single-payer arrangement.

But there is another option. Senator Daschle was alluding to a State-based system. Dr. Enthoven is here today to talk, I presume, about a framework of competing private plans, which could be a framework under the umbrella of universal health insurance.

In the State of California, the Insurance Commissioner, John Garamendi, has presented a very interesting and promising proposal for a universal insurance system that is based on competing plans and that does not require national financing.

And I really want to urge all of you today to consider this alternative approach which is not on the table, which was not listed when many of you summarized many of the different options at the Federal level.

Let me emphasize some of the arguments for moving out of an employment-based system. We usually hear about the questions of access. An employment-based system does create gaps, discontinuities, and inequities in coverage and cost.

But there is the additional reason that the employment-based system is not good at controlling health care costs. Employers do not have the instruments, they do not have the knowledge, and they actually do not really have the incentive to become good, effective, countervailing forces in the health care market. Moreover, small employers are very poorly equipped to become effective agents at controlling costs.

Third, the more we talk about moving to managed care and other forms of health insurance that are intrusive, that begin to interfere in choice, the more I think we ought to ask ourselves as to whether employers should be doing this.

Why should your employer be managing your health care? My employer does not manage anything else about my life, my housing, food. Why should employers be managing health care? I do not think they should.

Employers also do not derive any real benefit from serving as the intermediaries. They have become entangled in this system and it would be in their interest to extricate themselves from it.

So, we need to think about moving out of the system, putting an end, saying it is time for them to give up this role of being intermediaries. But, as I say, there are other alternatives besides moving to a single-payer system.

The ultimate objective of systemic reform, as I see it, is really to reach deep inside the process of health care and to change the way everyone concerned—doctors, patients, managers—thinks about the decisions they face.

At the core of the problem are the practice styles of physicians, governing their everyday choices about when to order tests, hospitalization, surgery, further visits.

Reform works best when it promotes a high quality, but conservative practice style; conservative in the sense of conserving resources.

Today, all too often, doctors take uncertainty as grounds for treatment, even aggressive therapy with high risks.

But how to create a more conservative practice style? That kind of radical change in orientation will not spring up naturally. It will not spring up just by changing the malpractice laws. There are essentially, I think, two strategies to bring about, to induce that kind of a shift in practice patterns.

One strategy calls for budgetary control from the center, and the other for competitive organizations generating decentralized cost sensitivity. Now, almost everybody emphasizes the ideological differences between those approaches, but they actually have a lot in common.

Both strategies involve the creation of effective countervailing forces against the health care system's internal tendencies toward expansion. I can address in more detail later how that works.

[The prepared statement of Dr. Starr appears in the appendix.]

The CHAIRMAN. Well, I certainly agree that the market system does not seem to be working.

Dr. Enthoven, it looks like you have an ally in Dr. Starr, here. I am surprised by the situation where he is talking about a single-payer and he seems to find common ground with you in the possibility of managed competition, by setting up several HMO's, perhaps, under a single authority. I would like for you to develop that a little more for me.

I see Dr. Starr is talking about eliminating employer-based health insurance and replacing that with a central authority that will promote the managed competition, as I understand it.

Who would you think would be in charge? Would you have a single, central authority administering that, setting up that kind of competition?

Professor ENTHOVEN. Well, let me just say that Dr. Starr and I have spoken by phone a couple of times in the past week or so, and I think there is a good deal of common ground; a feeling that somehow we have to achieve countervailing power. Now we have a very well-financed, well-organized array of provider organizations, insurance companies, and so forth on the supply side of this industry, and, on the demand side there is weakness, fragmentation, lack of information. Employers have certainly not done a decent job of buying health care in this country. They are not motivated, they do not

have the tools. So, how do we get there from here? Again, let me come back to PERS, if I may.

The CHAIRMAN. All right.

Professor ENTHOVEN. Here, we have for public employees in California a kind of broker agency that acts as the sponsor for 800,000 people.

What PERS does is to set the rules, which includes that if you participate, you take all comers, you serve them for the whole year, you charge the same price for everybody in the system. That used to be called community rating.

You meet our standard of our benefit package, and so forth; continuity of coverage, no cherry-picking, all these rules of good behavior. And the health plans that participate contract with PERS and they are offered in an annual open enrollment.

Now, it used to be that one huge defect in the system was that we did not have enough consumer price sensitivity, but in the past year that has been changed and now the State contributes a fixed dollar amount. So, if an employee chooses a more expensive health plan, he has to pay the difference in price.

One of the big advantages is that this has gotten away from some of the overpowering disadvantages of the employment-based system because we are managing it on a larger scale with a professionally competent staff. We run PERS for $4 million a year, which is $5 per person, per year.

You are concerned about administrative costs in small employment groups. We run this for $5 per person, per year. There is a good deal of choice there. We have 21 HMO's and 6 Preferred Provider Insurance schemes. So, any reasonable choice that somebody might have is likely to be represented there.

But there is, now, financial responsibility. That is, if you choose a more expensive plan, you pay for it yourself. And, therefore, what PERS has brought about, even with its inadequate price sensitivity in the past, is it has brought about a very rapid transformation from the cost-ineffective fee-for-service plans to the HMO's. More and more, the HMOS, especially the more cost-effective ones, are gaining in market share.

In fact, our traditional indemnity plans had to drop out a few years ago. The same thing at Stanford. We do not offer traditional indemnity insurance anymore. We only offer HMO's and PPO's because the other things cannot stand the competition.

The CHAIRMAN. Let me ask, from a tax standpoint, would you put a limit on what you would give in the way of a tax deduction? Would you have a basic package? Did I understand that? Would you have your deduction up to that point, perhaps, and above that you would lose it? Or how would you work that?

Professor ENTHOVEN. Well, the idea is, you could have, from your employer, tax-free the price of the low priced plan meeting defined Federal standards.

And, by the way, here, I am talking about a model in which—in PERS or at Stanford—these are mostly HMO's, in which case we are talking about quite comprehensive benefit packages. The people in the system are well-covered.

Then, what I would recommend from a tax point of view is to say, you can have tax-free from your employer the price of the low-

priced plan. Anything above that, you pay with your own net after-tax dollars. And that is very important to establish to create price elasticity of demand, price responsiveness to demand.

The CHAIRMAN. It also provides a source of revenue to try to pay for some of these people who are not covered at all.

Professor ENTHOVEN. Right. Definitely. It would provide $10–$15 billion a year. Richard Kronick and I published in the New England Journal a few years ago a proposal along these lines, and CBO kindly estimated for us that a limit like this would save $12 billion a year, which we proposed to be one of the main financing sources for buying access for those who are now uninsured.

The CHAIRMAN. All right. Senator Packwood.

Senator PACKWOOD. I do not have any questions right now. I may when the panel is done.

The CHAIRMAN. All right. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you. Ladies and gentlemen, thank you very much for your testimony.

Let me try an example of national health insurance and let me try it on you, Paul, and get other people to react. Ron Pollack has this great story he tells about when Claude Pepper died, went to heaven, and he asked the Lord, will we ever get national health insurance in the United States, and the Lord says, I have got good news and bad news. The good news is, yes, and the bad news is, not in my lifetime. [Laughter.]

But I think Paul is probably on the right track. And let me just try an example on you and we will see what we are talking about.

If we talk about a national or universal health insurance system as providing equal access to superior quality care for all Americans via universal coverage of financial risk, the way we would do it is everybody in the country would be required to own a health plan. We commonly call these health insurance now, but we can debate what they are. Let us call them a health plan. It would have a set of basic benefits in it, and a stop loss feature to protect, in some way, on financial risk.

The price would be allocated across the population, in some way approximately community rating, in order to get the price kind of right and more affordable.

But, then, given the fact that 95 percent of the people in this country probably still could not afford that plan, we would then have to go to subsidize the access to that plan for a lot of people.

So, let us assume we took that on as a national responsibility and we reform our current tax policies, which, next year, will produce $132 billion in Federal tax spending just for the employer-paid portion of it; and our social insurance policies, so that low-income people will have a portion of their premiums paid based on their income; and we restructure Medicare so that it is only one plan, not three, and it has a way to access long-term care. Would that meet your definition of national health insurance?

Dr. STARR. Well, unfortunately, if there is not an organization out there that is able to manage this competition among the alternative plans, the plans will seek to enroll the healthiest people. They will seek what is the easiest strategy to keep their costs down, which is not to have sick people among their enrollees.

So, you need an agent out there able to combat that opportunistic strategy which they will naturally follow, and competition will drive them to follow it. So, I do not think you can do without a governing authority in the market.

In the Garamendi plan, these are health insurance purchasing corporations. They resemble entities that Professor Enthoven has described before.

And, in addition, I think you have the further problem that in some parts of the country, the model of competition simply does not fit. You have disperse populations where you will be lucky if there is one provider, much less competing groups of providers.

Senator DURENBERGER. All right. Anyone else want to comment?

Professor ENTHOVEN. I would just agree with Professor Starr that the whole issue of risk selection is important, and that is why I think we have to envisage the agency that is running this as an intelligent, active agent that is watching what is going on.

And one of the first things that should be done is to standardize the benefit package, because that is a great tool for selecting risks, as we see in the mismanaged Federal Employees Health Benefits Program, for example.

And, secondly, we need to put in a set of risk adjustments where the relative medical needs of the population groups enrolled in the different groups are measured, and them compensatory payments are made from the low-risk to the high-risk in order to demotivate risk selection, to take the benefit of risk selection out of it from the point of view of the health plan.

Senator DURENBERGER. You have all been here for more than a couple of hours, and I think you can tell by the questions being asked here that there is not a lot of confidence in the current marketplace in health care, that it has not always demonstrated its effectiveness.

But, let me just posit this question to you. Many of the comprehensive reforms get to some kind of productivity. I call it static productivity, the one-time savings, whether it is $10 billion, $20 billion, whatever it is, in administrative savings. You can go to a single-payer system and you can eliminate various things.

But I would posit to you that none of them can give us ongoing, dynamic productivity or savings because they do not depend for their success on changing the behavior of anybody in the system, whether it is health plans, or insurance companies, or employers, if we still had them, or people, or doctors, or hospitals, or anybody else. Is that a fair statement?

Professor ENTHOVEN. No, I do not think that is right at all. I think that in an appropriately structured competitive environment, that the successful integrated health care financing and delivery plans would be the ones that motivated the conservative practice that Professor Starr is talking about, and that effectively implemented continuous quality improvement, which would be dynamic productivity. And I believe that there are large opportunities for that kind of productivity improvement.

In fact, at Stanford Business School now, I teach a course on Total Quality Management in Medical Care, and my students are involved in these projects. And it is very impressive, the gains that can be achieved, that are just out there waiting to be achieved.

Just to give you an example, last spring one of my students was in a project in Stanford Hospital, the assignment of which was, reduce the turn-around time for pap smears, which is now 4 to 6 weeks.

They analyzed the whole thing in the appropriate Deming sort of way; they went through all the right steps that, until recently had never happened over there or in any other hospital in America, and they cut the turn around time down to 2 to 3 days, without any increase in resources, just by getting everybody in the process together, doing a process flow diagram, taking measurements about where were the bottle-necks, and so forth. They were applying the same kind of techniques that we associate with Honda and Hewlett-Packard, and they work.

I do believe that there is real scope for dynamic productivity improvement if you can get the incentives right so that the survivors in this competition are the ones that figure out how to do that as a way of life.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Dr. Davis, in your summary, you state that health care expenditures in the U.S. have risen to 12.4 percent of gross domestic product and are out-pacing other industrialized nations.

We previously looked at some charts from the OECD that pointed out that per capita health care expenditures in Canada are rising at a more rapid rate than in the United States.

I think the point follows up on what Senator Durenberger said, that you realize initial savings in a single-payer system in terms of reduced administrative costs, but somehow we have got to infuse into the system some responsibility, some individual benefit from holding down the costs, which is what Dr. Enthoven is discussing.

Can you briefly point out where you got your figures from, where you say we are out-pacing other industrialized nations' rate of increase, not in dollars, but in percent?

Professor DAVIS. Yes. I also rely on OECD data, and I was listening with interest to your exchange with Dr. Reischauer. I think it is inappropriate to look at the rate of growth of per capita expenditures and compare that across countries.

Take two countries: one doubles prices or real wages over a 10-year period, the other has a 50 percent increase in prices and real wages over a 10-year period.

And, in Country A, health expenditures double, in County B, health expenditures go up by 50 percent. The health system is not better controlled in Country B, it is just that prices and real wages in that country are not going up.

The right way to think about this is health spending relative to the GNP or the Gross Domestic Product. And, if you look at that, over the 1980's, Canada was flat as a percent of GNP; the United States was increasing.

And, if you take my figures in Chart 10, in 1990, using OECD data, Canada, on a per capita basis, spent $1,80; the United States spent $2,600 per capita. So, it is fallacious to look at per capita trends in spending when you do not adjust for inflation trends, and wages, and rough GNP.

Senator CHAFEE. Thank you. I am very short of time here. I will review your figures. It seemed to me, from the prior testimony of Dr. Reischauer, what he was saying, is that ultimately somebody has got to make some tough decisions.

Politicians have to make tough decisions. There can be tough decisions made under the existing system if somebody wants to step up, for instance, and cut down on the amount of equipment available for everybody using Certificates of Need.

But, for instance, under Dr. Enthoven's proposal, everybody is not going to be terribly happy. A GM worker is not going to be very happy who currently has all his health care benefits as a tax-free fringe benefit, paying no taxes on them.

Let us say that GM is paying $6,000 per family for a married worker. Under your system, that might well be cut back.

Professor ENTHOVEN. He would get membership in Health Alliance Plan in Detroit tax free, and that is the best quality medical care in Detroit.

Senator CHAFEE. Right. And that may well be——

Professor ENTHOVEN. He would not choose the other one if he had to pay for it.

Senator CHAFEE. That is right. He might get the $4,000 program, but he would not be getting the $6,000 program tax free.

Professor ENTHOVEN. Right.

Senator CHAFEE. So, there are tough decisions that have to be made under this approach.

Professor ENTHOVEN. Yes. Right.

Senator CHAFEE. And everybody better recognize that.

Professor ENTHOVEN. Yes.

Senator CHAFEE. For example, under the national health insurance program, it might well be that the benefit package would not be as generous, Dr. Pauly, as what some workers are currently getting.

Professor PAULY. For some people, sure.

Senator CHAFEE. For some people.

Professor PAULY. The main consequence is likely to be, at least initially, not so much foregoing services, as finding them less convenient: having to travel further, having to wait a little bit longer, and so forth. But there will be some reduction in well-being of some people, no doubt.

Senator CHAFEE. That is right. And the payoff is that some others will be doing better.

Professor PAULY. Some will be doing better, and there may be payoff to those individuals, too. The care is less convenient, but they save a lot of money. And that is the reward that even the auto worker in Detroit may respond to if we remove the tax distortion so that he can pocket 100 percent of the savings.

On the other hand, as Alain suggests, if he is willing to spend the extra $2,000 out of after-tax earnings to get care on demand, it does not hurt anybody else.

Senator CHAFEE. Dr. Enthoven, how has your system worked in California as far as the rate of increases that your providers are having to ask for?

Professor ENTHOVEN. All right. The crucial thing, Senator, is my system has not been tried in the sense that price sensitivity, hav-

ing to pay the extra cost out of net after-tax income has not been tried. So, I regret to say, experience is close to zero. Now, let me just tell you about two employers, though, where we have tried it. One, is PERS. This last summer, the Governor froze the employer contributions because of the State's fiscal crisis. And a fascinating thing happened: five of our HMO's actually came in and said, "if you are going to do that, may we lower our prices in midstream by substantial amounts?"

This winter, we negotiated the new prices for next year. Five or six of our health plans actually offered price reductions. About 12 of them offered raises in the range of zero to 5 percent. So, we did experience for PERS a substantial reduction in the rate of growth.

A similar thing has happened in the State of Minnesota where the public employees and the employer have made a very wise agreement. The HMO's compete in each county, and the State, as employer, pays the price of the low-priced plan.

And reports of their experience over the past 3 years show that the rate of growth in their premiums has slowed drastically and the market share of their most cost effective plans has picked up.

However, in both cases, unfortunately, those employment groups still have to swim in a sea of other employment groups where the employer is paying the whole thing and the choice of fee-for-service is tax subsidized. So, I had to warn my own employer. We made a similar change at Stanford, and I am chairman of the Benefits Committee, so I sold the idea to my leaders out there.

And I had to warn them, if we at Stanford alone make this change and nobody else does, it is not really going to solve our problem. The costs are going to continue to soar. But, if everybody in the area would make the same change, we would get a price competitive system.

And the single thing that would help that along the most would be if the tax law were changed to say you can have the low-priced plan tax free.

There are a lot of different ways you might come up with that. I would like to see us get it through large-scale purchasing cooperatives, but get that price so you can have that tax free. But, if you choose something more expensive, you pay for it with your own money.

Senator CHAFEE. Thank you, Mr. Chairman. Thank you very much, Doctor.

The CHAIRMAN. The Majority Leader.

Senator MITCHELL. Mr. Chairman, thank you very much. Dr. Enthoven, your proposal has attracted a great deal of attention and comment, much of it favorable, much of it unfavorable.

I would like to submit to you a critical article that has been written, which I assume you have previously seen, and ask that you would respond to the critiques in writing. The few minutes that we have in this question and answer period does not permit the full exploration of those points.

[The information appears in the appendix.]

Senator MITCHELL. I would like to ask a couple of questions, and I will ask what are a series of questions and ask you to respond to them as best you can in a short time in narrative fashion.

As you know, the principal criticism of your proposal is that it is theoretical in nature and there are many who allege crucial details are absent: Who would make decisions about limiting the numbers of participants in the health insurance purchasing cooperatives? Who would decide membership in the different types of such cooperatives?

How would this work in rural areas? I come from a State in which it has been very difficult for HMO's to gain a foothold because of a relatively small population spread over large land areas; the same description applies to several States represented on this committee.

Most importantly, how would you avoid adverse selection, and particularly adverse selection by income, which was the subject of one specific and very detailed criticism that appeared in the New York Times following a favorable analysis and a favorable presentation of your plan in an article in the New York Times by yourself and others. So, could you give us just some general idea.

Professor ENTHOVEN. Sure.

Senator MITCHELL. I know you cannot answer them all in 3 or 4 minutes.

Professor ENTHOVEN. Well, with respect to theoretical in nature, I am talking now about the experience of about 40 million Americans who are in HMO's. And we do just fine, and we do not have a lot of problems that the rest of you people have.

My HMO provides good primary care access because they hire enough primary care physicians, et cetera, et cetera. So, I think I am talking about building on some successful experiences.

That is a pretty large demonstration project. And, while it has not solved the whole thing because of a lot of perverse incentives out there, it has also improved things for those of us who are in that system.

I will grant you that, with respect to the health insurance purchasing cooperatives, which is a fairly new idea, that there are crucial details that have not been sorted out. I am working hard on that myself. I would encourage you to think about it and work it out. So, I will grant you, quite frankly, I do not have all the details. But what I can tell you is I can point to some successful examples where this seems to be working quite well. One, is the Public Employees' Retirement System in California. That has been up and running for a long time. We finally introduced price competition. Minnesota State Employees are another example.

Who decides membership? Do you mean who decides who is going to be in which plan? In all of these, the memberships are driven by informed, price-conscious consumer choice.

At Stanford, where we have three HMO's and a Preferred Provider insurance scheme, each year I decide which plan I am going to be in.

And I do not see it as being a big barrier to my choice, because all of the significant providers in the community are in one or another of those arrangements. So, I am not suffering any diminution of choice there.

Three-quarters of my Stanford faculty and staff colleagues are in HMO's and we think that is fine.

Senator MITCHELL. Would you grant that the faculty at Stanford is probably in a better position to make informed choice than many other Americans who are without that level of education?

Professor ENTHOVEN. Well, I would not overstate that, Senator. [Laughter.]

I would not overstate that. They need a lot of help, and that is why I agree with Paul Starr. We need to have a sponsor, a collective purchasing agent that does the contracting, monitors the contracts, makes sure that they are all carrying out their responsibilities, and so forth.

That is where my good friend, Mark Pauly, and I part, in that I think his model is too much individual choice without enough beneficent involvement of sponsors. But, anyway, on who decides the membership, I am talking about consumer choice. Now, who decides which players get to play? The sponsor does that. And there, I realize you have got important issues of governance.

For CalPERS, it is the PERS board that decides whether Plan X or Plan Y is going to get to play or not. And we offer advice, this is a good quality plan, or it is not, or we do not need them, and so forth.

At Stanford it is the Benefits Office and the Benefits Committee. We make an informed business judgment on behalf of our community as to which plans will be on the menu.

With respect to rural areas, if we could get market forces working appropriately, I think that there are promising avenues. The best thing is where you can have satellites running out from metropolitan areas.

What they need in Minnesota, I think, and they have, to some extent, is rural primary care satellites affiliated with one or another major medical system in the metropolitan areas so that the doctors out there can get professional support, financial support, and tie into a larger system.

There are alternative models, individual practice HMO's of the kind represented by U.S. health care systems, for example, that are based on primary care physicians that I think could be made to work in rural areas.

With respect to adverse selection, I think there are methodologies that are able to deal with that. That is, especially on the demographic side as we are working on models now for PERS and for Stanford where we estimate the age, sex, family composition, retiree status of the people in the different health plans and make corrections for that.

With respect to adverse selection by income, come out to the San Francisco Bay area, or Los Angeles sometime with me and I will show you some HMO hospitals in some pretty bleak urban areas.

So, I think that it is not right to say this only works in the suburbs. There are HMO's serving the downtown areas of our major cities out there.

Senator MITCHELL. My time is up. I think the criticism was just the reverse, but that is included in one of the lengthy articles to which I referred, and I will get that to you in writing. I do not want to encroach on the time.

I merely would like to request that Drs. Davis, Starr and Pauly provide written comments on the questions that I asked of Dr. Enthoven and his plan.

I would be very much interested in your perspectives of the series of questions which I addressed to Dr. Enthoven, and I will submit the same articles to you. Thank you very much. Thank you, Mr. Chairman.

[The information appears in the appendix.]

The CHAIRMAN. Surely. Let me state for the benefit of those that are on the next panel that obviously we have run later than anticipated. Once we complete this panel, we will take a recess. And, assuming the members of the panel can be here, we will be back here at 1:45.

Now, with that stated, Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. Actually, the Majority Leader asked the questions I was going to ask. But let me just follow up on them. Let us take the number of plans and the nature of the plans that people could potentially subscribe to. Dr. Enthoven, is there any limit on the number of different plans that, say, the overall agency could allow to persons who may want to participate?

Professor ENTHOVEN. Well, I think that there needs to be some business judgment applied here. Let me just mention a few of the principles involved. First of all, what we need to be trying to do is to divide the provider community into competing economic units and then to get each of them to get to work, the doctors, the hospitals in that unit, to improve efficiency and improve quality, squeeze out the waste, and so forth.

Senator BAUCUS. What I am really getting at, though, is there is no real limit and then we are kind of back in the soup again. We have all of these different——

Professor ENTHOVEN. All right. But I think that that generally is going to imply a limit. In the San Francisco Bay area we would probably have somewhere between 6 and 12 organizations competent to do this kind of a job.

Senator BAUCUS. All right.

Professor ENTHOVEN. I am not in favor of offering plans where you have overlapping networks. You know, if you have three IPA's in town and they all cover the same doctors, that is not competition, so you do not need those.

Senator BAUCUS. All right. If I could, because we do not have much time, could you expand a little more about the problem of adverse selection? It concerns me under your scheme.

Professor ENTHOVEN. Well, I think that adverse selection is a serious problem that requires careful management and I have recommended a comprehensive management strategy for how to manage it. It includes standardizing the benefit package.

If you allow the individual health plans to design their own benefit package, as has been done in the Federal Employees Health Benefits program, for example, which is, in my view, a very serious mistake, then you are going to get all kinds of risk-selecting behavior.

So, the first thing I would say is you have to standardize the benefits package; that is, the contract that is being offered, the things that are being covered.

Senator BAUCUS. Among all plans.

Professor ENTHOVEN. All plans standardized.

Senator BAUCUS. That is number one. What else?

Professor ENTHOVEN. Then you need to do risk adjustments. You should measure, to begin with, the age, sex, family composition, retiree status, and any other variables that you can measure reliably, and turn that into a factor that measures the riskiness of the enrollment of the people in the different health plans, and then make compensatory payments.

Senator BAUCUS. Now, how would you make compensatory payments?

Professor ENTHOVEN. Well, you want a little technical discourse here?

Senator BAUCUS. Well, the bottom line.

Professor ENTHOVEN. All right. The bottom line is, you figure out the number that says, this plan which got average risks has an index of one. This plan that got a little worse than average risks got an index of 1.02, let us say. And the other one that got favorable risks got 0.98.

Now, what you do is you figure out, what is 1 percentage point of selection worth, and it is worth 1 percent of the price of the efficient plan.

Senator BAUCUS. Is this not getting a little complicated for a lot of folks?

Professor ENTHOVEN. No.

Professor DAVIS. If I could interject, I think it gets more complicated than that. I think the competition, by creaming out the healthier risks, is the fatal flaw of managed competition.

What Professor Enthoven is talking about is the straightforward stuff of adjusting for age and sex. You can set different premiums based on age and sex. What you cannot do, with our current knowledge, is really adjust for the health status of those populations.

So, even if you regulate these plans, as Professor Starr has recommended, and try to have uniform benefits, try to make them open to all comers, they can locate their clinics in areas where people have higher incomes, where you do not have AIDs, where you do not have drug abuse. They know how to cream-skim. They know how to segment the market.

And there is no way, analytically, to try to compensate or risk-adjust a health plan that gets a disproportionate share of boarder babies, that has a disproportionate share of chronically ill children.

And, with our new techniques coming up in genetic screening, they are going to know who is at risk for Alzheimer's, who is at risk for Huntington's Disease. And, as the market works now, they are going to avoid those people like the plague. And there is no way to get them to take them.

Senator BAUCUS. What about that, Dr. Enthoven. That sounds like a pretty difficult problem there.

Professor ENTHOVEN. Well, I think that there is research under way on health status, and I think it will be possible to bring in

health status indicators. I think that it is important to have a single point of entry. That is why you have a sponsor.

Again, if I give the example of Stanford, all of the people on the faculty and staff at Stanford make their decision, notify the Benefits Office, who notifies the health plan.

Senator BAUCUS. I appreciate it. My time is about up here. I want to ask you about rural areas.

Professor ENTHOVEN. Yes.

Senator BAUCUS. I read in your statement here that CalPERS covers 800,000 California public employees. That is the entire State of Montana.

Professor ENTHOVEN. Right.

Senator BAUCUS. So, what about the farmer out there who is self-employed, or the gas station attendant, or the single parent? I mean, some folks in Montana live in cities—towns, by California's standards—and do pretty well.

We have a very high percentage, way above the national average of people who have no health insurance. So, how are you going to apply your system to everybody in the State of Montana? When you talked about rural areas, to be totally candid with you, I do not think you fully appreciate how rural some of these rural areas are. There is a lot of distance between some of these——

Professor ENTHOVEN. Well, I will tell you, I have spent a lot of time in Wyoming in recent years and was your neighbor, and I thought about the situation there.

I do not think there are easy answers, but I think that it would be trying to get the incentives right, trying to get networks, Preferred Provider or individual practice type networks that sign up the doctors and work with them, look at the health care system and figure out how to make care accessible.

I think one of the things is just to get stable purchasing power out there in the hands of those people. That is why universal health insurance is so important. And then have competing individual practice networks.

Senator BAUCUS. Thank you very much. My time expired. Thank you.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. The plan that Senator Wofford and I have introduced would allow the States to do pretty much what John Garamendi has recommended that they do in his California plan, and that is to induce managed competition under the auspices of the type of governing body that Dr. Starr has talked about.

There has to be a governing body, and I think three of the four witnesses, at least, would agree with that. A governing body to determine the basic benefits plan.

Professor ENTHOVEN. Right. Yes.

Senator DASCHLE. And it seems to me that the next step is, once you have determined the basic benefits, to allow for a contracting out of the individual insurance services to be provided for that basic benefits package.

You may want competition for acute care. You may want competition for long-term care; competition for home health care. But,

in other words, all of the services would not necessarily have to be provided by one insurer.

I could see several different levels of competition for the various services to be provided and the contractors would know two things when they were bidding for that contract. They would know, number one, the people they were serving.

That is, all of the people of South Dakota would have to be covered by the product that they would be providing. And, number two, they would know that the basic benefit would be described very clearly in the contract.

So, it seems to me you have a managed competition in the sense that Dr. Enthoven describes it, but with the governing board that Dr. Starr has said is very important. Dr. Starr, could you elaborate? Is that not the system that you have outlined, and why would that not work?

Dr. STARR. Well, I think that is one structure that could be used by some States, and, indeed, perhaps a State like yours would prefer that kind of structure to the one that Professor Enthoven has outlined.

Now, yours does not provide for the kind of cost sensitivity by consumers. Consumers are not making choices among alternative plans in the model that you have outlined, rather, the board is making choices among different contractors.

So, it is a different model. But I think there may be States where that fits better, and that is why I tried to emphasize that you can set this up as a series of options to the States.

In some places, like California, where you have well-developed competing pre-paid health plans, the structure that Dr. Enthoven and Mr. Garamendi have outlined make a great deal of sense. But, in your State, that may not be the case, and, there, the single sponsor can become, more or less, a single-payer.

Senator DASCHLE. Dr. Enthoven, do you disagree with that?

Professor ENTHOVEN. No, no. I think that is a very reasonable point of view. I mean, I share that. I think you do have to have a sponsor. That is why I have used the term "managed competition" as opposed to "free market competition."

Somebody has to be managing it for a defined population. And it has to be an intelligent, active agent that is watching these problems and then taking counteraction where bad things are happening.

On the whole question of risk selection, I would just say if the insurance companies can figure it out, then the sponsor has got to be smart enough to figure it out, too, and come up with the countervailing strategy.

Senator DASCHLE. We also would allow any individual to buy supplemental benefits like we do with Medicare, because we do not really anticipate that all of the benefits would be provided in the basic benefits plan that take you from the very base of the health care pyramid to the very top.

Professor ENTHOVEN. Well, I do not know. My view is that the covered benefits ought to be fairly comprehensive. I mean, if you are thinking, well, we would not cover pharmaceuticals, for example, leave that outside and let people buy pharmaceutical coverage independently, that does not make much sense at all to me.

Senator DASCHLE. Oh, I agree.

Professor ENTHOVEN. Because sick people with chronic diseases need pharmaceutical. The procurement of those and the management of those ought to be done by their HMO that is trying to use them in such a way as to produce the best possible health outcome for the least cost.

Senator DASCHLE. I agree. But you may want a private room.

Professor ENTHOVEN. Oh, that is trivial, private rooms.

Senator DASCHLE. You may want other kinds of things that are not related to basic benefits.

Professor ENTHOVEN. Yes. All right. Fine. If you want a private room, go for it. I mean, that is such a small part of the costs. Some of our Kaiser hospitals have private rooms because they found it was more economical not to have to juggle the smokers and nonsmokers, the men and the women, and all that, just have single rooms. And then the doctors found, no, it is really better to have somebody have a roommate for companionship. That is not an important economic issue.

The really important economic issues in this are things like open-heart surgery. In California, more than one-third of the hospitals doing open-heart surgery are doing it at dangerously low volumes. That gives you high death rates and high costs. And maybe half of the open-heart surgery is inappropriate.

So, what we really need to do is cut the open-heart surgery in half and have it all concentrated in a few high-volume centers. That is the way you achieve economy in health care. So, sure. People want to buy a private room. Yes.

Senator DASCHLE. I just cite that as an example. But I think there are things that would not necessarily be covered in the basic benefits plan.

Professor ENTHOVEN. Dentistry.

Senator DASCHLE. That might not have been the best example.

Professor ENTHOVEN. Yes. All right.

Senator DASCHLE. Thank you, witnesses. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman. I do not mean to keep you very long, but I do have just a couple of questions that I would like to ask of the whole panel.

I would like to ask each of you to respond in discussing the complex issue of what incentives could be built into the system to promote cost-reducing technology, and, at the same time, discourage increasing costly technology. Shall we just start with you, Dr. Enthoven, and then just come right across the panel.

Professor ENTHOVEN. Well, if the technology decisions are being made by integrated health care financing delivery plans that are at risk, then their place in the market place is going to be jeopardized if their costs are out of control. They are going to be rewarded by identifying and using cost-reducing technology.

Just as a simple example, out in California, the HMO's were out in front on introducing day surgery, ambulatory surgery, because they saw that as a cost-reducing technology. And I think that kind of model provides a lot of incentive to do that.

Senator HATCH. All right.

Dr. Davis.

Professor DAVIS. Well, I would say the best incentive for cost-reducing technology is some kind of system like expenditure targets, or global budgets, or budgets for individual hospitals. It is hard for hospitals to really have a stake in improving productivity and efficiency if doing that reduces your revenues.

But, if you get a flat budget or you are working within the system of an overall limit on expenditures, then you have got a real incentive to introduce that kind of technology. I think that is why, when we look at the experience of other countries, you do find that costs are much lower.

They also use other mechanisms, such as emphasizing training of primary care physicians instead of specialists, regulating capital so you do not get duplication of coronary care units, complex services in multiple facilities.

Senator HATCH. Dr. Starr.

Dr. STARR. Well, let me try to synthesize what Professor Enthoven and Karen Davis have said. If we have budget constrained organizations, which are either pre-paid health plans in a competing framework, or hospitals under global budgets, they will begin to have more of an incentive to look for the cost-saving technologies than we now have in our current structure. Either one of these begins to impel organizations to look for those alternatives.

There is going to be a need, however, under any of these alternatives, for some kind of upstream regulation of technologies, because it is very difficult, even in the competing format, for plans to resist certain technologies that become either highly popular or are defended under the malpractice system. Take autologous bone marrow transplantation today, which is being used, in many cases, inadvisably, because of the legal pressures.

So, if you do not have some kind of upstream regulation, I am afraid the market alone will not take care of that.

Senator HATCH. Dr. Pauly.

Professor PAULY. Well, hospitals do not adopt cost-increasing technology just for the heck of it.

Senator HATCH. That has not been my experience either.

Professor PAULY. They usually do it because it provides a little bit of benefit, or maybe sometimes a lot more benefit than the alternative it is replacing. A solution to that comes in two stages.

One stage, as has already been suggested, is to confront the hospitals with some kind of fixed-price discipline, and the second stage, which, in a way, is more important, is to structure incentives for consumers to be able to choose among alternative health plans, setting what that fixed price discipline is to be.

And, as I emphasized in my remarks, the most important thing to do to bring that about is to remove the current distortive tax subsidy.

I want to take the opportunity, since we have not had much of it, to disagree with Paul. I do not see why you need an upstream regulator of technology.

If health care plans are competing for customers' business, customers who are properly informed about various versions of technology, then they are, in a sense, regulators.

The difference is, of course, as consumers you can pick your own regulator by what health plan you join rather than having the regulator that is forced on you by the votes of your fellow citizens.

And I see no particular reason, if my health plan wants to adopt autologous bone marrow transplantation and can convince me it is worth the extra money for the premium, fine. If not, not. And that seems to be the way markets work generally, and presumably the way they would work here.

I do not see any imperative driving the adoption of technology that is not worth its benefit in a world of no incentives without distortions.

Professor ENTHOVEN. May I just comment on that? Mark, I just think that is really totally unrealistic. I think Paul is right. That is, for one thing, you have got the problem of risk selection sloshing around there.

Professor PAULY. No argument about that.

Professor ENTHOVEN. All right.

Professor PAULY. Take that away.

Professor ENTHOVEN. Some health plans offer a given technology; other ones do not. All of the people that need that are going to join that health plan. So, I do think that there has to be some authoritative public body that is deciding——

Professor PAULY. That is not what he was talking about.

Professor ENTHOVEN. All right. That is the first thing. The second thing is there are intense consumer demands for technologies that are of no proven efficacy. And these days, what is happening is some HMO's and insurers are trying to deny coverage, saying there is no proof that that technology is valuable.

And the patient takes it to the press and takes it to the courts and the HMO or insurer gets crucified, and sometimes they have been forced to provide it, even though there is a perfectly legitimate medical judgment that it has no value.

So, I think we must create in this country some kind of authoritative collective decision process that can say these technologies are or are not proven, or are sufficiently cost-effective for these indications, that they are or are not included in the insured benefit package.

Senator HATCH. Mr. Chairman, I hate to keep you. Could I just ask one follow-up question?

The CHAIRMAN. Of course.

Senator HATCH. It seems to me you all seem to be saying that we must continue to develop technology. But how can we provide incentives to guide the development of new technology? It seems to me that that is a logical question.

Professor ENTHOVEN. Well, if the customers are all HMO's or all HMO-like entities, doctors at risk, they are going to be very interested in cost reducing technologies and they are going to have very attenuated enthusiasm for adopting cost increasing technologies.

And, where they do adopt them, they are going to do it on a controlled, regionalized basis if you have turned the incentives around in favor of economy.

Senator HATCH. Do you also agree with Dr. Starr that something has to be done regarding medical liability, if we are going to develop cost-reducing technologies?

Professor ENTHOVEN. Sure.

Senator HATCH. And if we do not do that, my gosh, there is a disincentive to develop them.

Dr. STARR. Can I just add one point here?

The CHAIRMAN. If you could, and then let us wrap it up with that.

Senator HATCH. Yes.

The CHAIRMAN. All right.

Dr. STARR. Many people talk about technology as if it were an unstoppable force of its own.

Senator HATCH. Yes.

Dr. STARR. But corporations have to invest in bringing technologies to market. They are going to worry about what kind of a market exists out there. And if the nature of that market changes, so will the technologies being developed.

Senator HATCH. Well, thank you.

The CHAIRMAN. Yes. Yes, of course, Senator. Let me say that Senators, like Senator Hatch, have been juggling three committees at the same time this morning.

And, through most of this, we have had a very substantial number of the members here, even with those kinds of demands, which demonstrates the intensity of the interest and what I think will be certainly one of the most important issues to be resolved by this country this year or the next. You have made a substantial contribution to the discussion. We are very appreciative of that.

We will be meeting back here again at 1:45 with the next panel. We look forward to seeing them then.

[Whereupon, the hearing was recessed at 12:55 p.m., to reconvene at 1:45 p.m.]

AFTER RECESS

The CHAIRMAN. We will reconvene the hearing. I thank the members of the panel for being able to stay over and address these concerns with us.

We have today Dr. Drew Altman, who is president of the Henry Kaiser Family Foundation, Menlo Park, CA; Dr. John Immerwahr, who is senior research fellow for the Public Agenda Foundation in New York; and Mr. John Moynahan, who is executive vice president of Group Insurance, Metropolitan Life. He is accompanied by Mr. Robert Leitman, who is the senior vice president of Louis Harris and Associates.

Dr. Altman, if you would proceed.

STATEMENT OF DREW E. ALTMAN, Ph.D., PRESIDENT OF THE HENRY J. KAISER FAMILY FOUNDATION, MENLO PARK, CA

Dr. ALTMAN. Thank you, Mr. Chairman. I welcome the opportunity to testify. Two distinguished members of my board who are former colleagues of yours, Barbara Jordan and Dan Evans, send their regards.

We have been conducting a series of surveys designed to track how the environment of public opinion is changing; the environment in which, as Senator Chafee said this morning, we will all have to make tough decisions about health reform.

Today, what I would like to do is report mainly on the 2,000-person, national random-sample survey we released on April 8. This survey was conducted for us by Louis Harris and Associates, and also funded by the Commonwealth Fund.

In my remarks, I am going to take a shot at reporting just six key findings, and have submitted a more detailed statement for the record.

The CHAIRMAN. All right.

Dr. ALTMAN. If I could direct your attention to page 11 of my testimony, table 2, that is where I will begin, and pages 11–20, generally, which is where I will remain.

Six major findings:

Finding No. 1. The public wants the Federal Government, not the States and not the private sector, to take the lead in solving the problems with our health care system. If there is a debate about this issue, the public is ready to settle the debate. I am on page 11, again, table 2.

We asked, who should have the primary role in providing health insurance to all Americans and controlling costs? And the answer was clear and overwhelming by a two to one margin: government, not the private sector; a response which held for both Republicans and Democrats.

We asked, well, then, if it is a choice between Federal Government and State government, which level of government? The answer, again, equally clear, Federal, not State government. It is interesting to us that only 3 percent of respondents said they wanted a joint Federal and State system. So, not shared, not private, not State: Federal.

Finding No. 2. This was the single strongest verdict in our poll. The public overwhelmingly supports direct government intervention to control costs, and this held for Republicans as well as Democrats.

If I could refer you to tables 4 through 5 on pages 12 and 13, we asked a series of questions about cost containment.

Should the government set the rates that insurers can charge for health premiums; should it set the rates that doctors and hospitals charge patients, and we asked also about drug prices.

The response was very clear and very powerful. Three out of four Americans, holding again for both Republicans and Democrats, answered, yes; the strongest support yet voiced for aggressive government action on cost containment.

This was not surprising to us. We have seen consistently in every survey we do that cost is the overwhelming issue on the public's mind. And, on page 15, table 8, you will see the most powerful reflection of that from a survey we did just after the Wofford/Thornburgh Senate race in Pennsylvania. This finding has a lot to say about what we emphasize in health-care reform.

Finding No. 3. We call this the beauty contest. The public is divided on the major options for reform. This is table 9 on page 16.

We asked, which of the following ways of financing health care would you favor? And we asked about play-or-pay, we asked about single-payer, and we asked about the President's tax credit plan.

And we found the public pretty evenly divided. We got, for your information, exactly the same result in a post-primary poll in New

Hampshire, and exactly the same result asking the question different ways in this poll, in an attempt to be fair in characterizing the different proposals.

Please note that only 2 percent of the public said, leave things the way they are. Only 8 percent were not sure how to answer. Ninety percent were willing to choose up sides in making a response.

We do suspect, as I am sure you do, that the public's understanding of these proposals is paper thin and somewhat superficial. But I think it is useful to note that the experts who live and breathe this issue have been divided all of these years as well.

So, it is unlikely, we think, that there will be a magic day when the public says, all right, we see it now, we are for Alain Enthoven's plan, or Karen Davis' plan, or whichever plan.

Finding No. 4. Health reform is potentially a big issue in the Presidential and congressional races. We found that if you give people a list of problems, they say everything is important.

But, if you ask, what will the most important issues, or the two most important issues be on your mind when you vote for President and Members of Congress? Health comes in a strong number two; far behind the economy, which leads by 2 to 1, but far ahead of a lot of other very important issues.

And this is a result which holds in Senate races and in House races as well, although somewhat less powerfully than in the Presidential race. This is table 11 on page 17. Other issues rise in importance when you move to State races, where health drops down to number 4.

The last point I think I want to make here, and I will just leave the rest for the record, is that while health is potentially a big issue, the number two issue on most voters' minds, no candidate or party has effectively tapped into this issue yet.

If the election were held today, health would not be much of a factor because we found that the public did not see a meaningful difference between the health reform proposals of either party or any candidate. These findings are summarized in tables 13 and 14 on page 19.

We ask, do you see any real difference between the health care reform proposals of Republicans and Democrats, or not? Only 16 percent did see a difference.

Can you think of any political leader or candidate whose proposal for health reform you support? The answer was no one. Eighty percent said no one; President Bush led with 5 percent; and Governor Clinton got 2 percent.

I see the guillotine has fallen; the red light is on. If I may quickly finish by saying that this finding is not surprising, given the stage we are at in the political process. It is at least possible that this will change dramatically when we get to a simpler world with two candidates from either party arguing philosophically opposed plans for health care reform.

Thank you very much. I will be happy to answer any questions you may have.

[The prepared statement of Dr. Altman appears in the appendix.]

The CHAIRMAN. Thank you.

Dr. Immerwahr.

STATEMENT OF JOHN IMMERWAHR, Ph.D., SENIOR RESEARCH FELLOW, PUBLIC AGENDA FOUNDATION, NEW YORK, NY

Dr. IMMERWAHR. Yes. I am John Immerwahr, the author of this report, "Faulty Diagnosis," which you have. I will just highlight a few points from it. This report is based on a series of 15 focus groups conducted around the country, and on two surveys conducted in conjunction with the Employee Benefit Research Institute by the Gallup organization.

What the survey and the research point to is a somewhat dangerous position. That is, on the surface, it appears there is a consensus among the public, and between the public and leadership groups.

But, if you probe beneath the surface, you find an alarming gap between where the public is and where leaders are. So, you have the illusion that people are ready for something, but what they are really saying is something quite different.

I will try to outline the research findings for you in three categories. If you would like, you can think about health care in terms of what the symptoms of the problem are, what the diagnosis of the problem is, and what the cure is. In each of those areas, I think I can show you some interesting differences.

On the symptoms, all of the studies show that everyone's number one issue is the cost of health care. That is certainly true for the public as well as for leadership. But, when you start talking to the public in more detail, you find they have a slightly different meaning of cost.

Not surprisingly, when people talk about costs, what they mean is how much they pay out of their own pockets, whereas, when leaders talk about costs, they talk about the $800 billion a year spent by the country as a whole. Moreover, many members of the public—and we do not have a precise quantification on this—believe that they themselves are paying the majority of the Nation's health care costs in their own share of premiums, deductibles, and other out-of-pocket costs.

In other words, people think that health care is like auto insurance. It is a problem; it is very expensive; some people do not have it, and they are concerned about it. But what people do not see is that, unlike auto insurance, their won share of health care premiums are only the tip of the iceberg.

Now, where this makes a difference is when you say to people, "we have a cure for the health care cost problem: you pay higher deductibles, higher co-payments." To the public, that is not the cure, that is the problem. So, it is a very different perspective.

Secondly, when you come to the diagnosis of the problem, the difference is really startling. If you talk to experts, as we heard this morning, they say it is a very complex problem.

Technology is a factor; the aging of the population, the lifestyle of the American public are factors. The problem is not susceptible to any single, one-time cure. Whereas, if you talk to the public, they have quite a different analysis.

According to almost everyone that we talked to, this is a simple problem. It is not a new problem. There is a single major factor that is very easily understood, and that factor is waste, greed, excess profits. In other words, in the view of the public, it is not that

we have a health care cost crisis, we have a health care profits crisis.

To give you an example, you have heard a lot of people talking about $125 toilet seats and the expense of coffee makers on military airplanes.

That is nothing, I would submit, compared to the way people talk about hospital bills. Everyone has a story. And they just did not read it in the newspaper, they saw it in their own hospital bill: $15 for a bag of ice, $5 for an aspirin.

If you look in today's New York Times, for example, there is a letter from a person outraged by a $600 bill for 15 minutes in the recovery room for a one-quarter inch incision in the finger. People just do not understand what is going on.

So, when you talk to people about limiting their choice, or giving to different health care delivery systems, they look at you as though you are crazy. They say, "we are paying $600 to sit in the recovery room for 15 minutes, and you want to limit my choice? Let us take care of that, first."

We found, for example, that 83 percent of the public—and that is a virtual consensus when you get those kind of numbers—believe that we could solve all of our problems, cover all of the uninsured by eliminating the waste, fraud, excess paperwork, malpractice—all of the excesses people hear about on the news every day. For them, this is the health care cost crisis.

Thirdly, when we move into the area of the cure, or the solutions, as Dr. Altman has suggested, what people say at this point about these solutions is very misleading.

For example, we asked people whether they favored national health insurance, and we got one of the highest numbers I have seen, 77 percent, saying they favor national health insurance.

But, if you take that as an endorsement for the Canadian plan, that is mistaken. In focus groups, we asked people whether they were in favor of national health insurance and what they thought it meant.

Some people described something like a Canadian-style system, but other people were much less clear. They would say, "national health insurance, well, that is where everyone has insurance," without suggesting who provides it. One person, for example said it was a government agency to study health insurance. Another thought it was a government insurance some people could buy. In other words, national health insurance is a phrase suggesting solution; it is not understood. Only 31 percent of those surveyed define it as the Canadian plan.

What I am saying, in sum, is that before we deal with this problem, there are severe obstacles that have to be addressed: people's honest concern with greed and abuse; their unwillingness to listen to any solution until that concern is both heard and addressed. There is also a great deal more education, and discussion, and debate that must take place to let people understand the real nature of this issue. Thank you.

[The prepared statement of Dr. Immerwahr appears in the appendix.]

The CHAIRMAN. Mr. Moynahan.

STATEMENT OF JOHN D. MOYNAHAN, JR., EXECUTIVE VICE PRESIDENT, GROUP INSURANCE, METROPOLITAN LIFE, NEW YORK, NY, ACCOMPANIED BY ROBERT LEITMAN, SENIOR VICE PRESIDENT, LOUIS HARRIS & ASSOCIATES

Mr. MOYNAHAN. Thank you, Mr. Chairman. Bob Leitman and I are pleased to be here today to present a brief summary of the findings of a unique survey which Metropolitan Life commissioned and released in the spring of 1991.

We feel it may still be of interest to the committee members as you deliberate on health care reform. It does remain, I think, the only major survey of which we are aware that targets leader groups as distinct from the general public.

When the need for reform is generally recognized, we think it is valuable to know the opinions of key health care leaders; those who are in a position to effect change, and upon whom we will, in fact, ultimately rely to improve the American health care system.

This survey covered more than 2,000 such leaders. It was designed to get them thinking about accommodation and to react to at least some of the avenues along which agreement might be reached.

In the first section of the survey, the majority of all stakeholder groups expressed the opinion that fundamental changes were necessary in order to make the system work better, and, that such reform is likely to occur.

Of the nine groups that also believed that change should come incrementally, only the union leaders felt that the change should be comprehensive and rapid.

A key objective of the survey, of course, was to uncover tradeoffs which stakeholders might be willing to make as a part of the total plan in which everyone gave up something. Each survey group said that they would be willing to compromise in order to achieve comprehensive reform.

I would like to highlight for you some of the more interesting tradeoffs which we found stakeholders willing to make. Physician leaders found it acceptable to be required to follow practice guidelines on how to treat different conditions, and requiring patients to obtain the prior approval of a primary care physician in order to see specialists, and being compensated on a fee-for-service basis, but entirely from a fixed budget with an expenditure cap.

Other reimbursement mechanisms were not acceptable, such as uniform national fee schedule for all plans, public and private, with no balance billing allowed; compensation only on a capitated basis, or a purely salaried basis. Perhaps there are no surprises, there.

Hospital CEO's were willing to treat all patients, even if reimbursement for some is below the actual cost and, marginally, to accept global budgets in a uniform one-payer system with prospective fees for all health plans.

Majorities of corporate executives, even of the smallest firms, agreed that being required to provide basic health benefits to all full-time employees was acceptable.

Now, keep in mind that this was in the context of a trade-off situation. On the other hand, CEO's generally felt that it was not acceptable that they be required to provide coverage to part-time employees.

Now, labor leaders found it acceptable to be limited to a standard health plan which would be the same for every employer, and also to be required to belong to managed care plans, such as HMO's. However, higher deductibles and co-payments were not acceptable. They are, they say, willing to work with management to contain costs of care if the savings would be used for wages, or to save employment or save jobs.

Now, as to the small employer insurance market, the 21 largest commercial carriers were surveyed, and, to the extent that a mechanism is available to spread excess losses that might occur, they showed a very strong willingness to provide guaranteed renewable insurance; to somehow guarantee issue regardless of health status, and to change other underwriting practices for the small employer marketplace. Interestingly, they also seemed to agree—74 percent—that in the context of tradeoffs and compromises, operating on some form of community rating in the small case market would be acceptable.

You should know, by the way, that Metropolitan Life is in the forefront of companies supporting small market reform, and we commend the efforts of the Chairman and members of this committee toward that end.

All stakeholders were asked, if it were part of the financing of a program in which all made compromises to reach a consensus, would higher income taxes be acceptable? Majorities of each group found higher income taxes acceptable.

Now, keep in mind that these are sophisticated individuals who likely understand the magnitude of the taxes that would be required.

Asked if they would be willing to accept a tax on health care premiums paid by employers, we had mixed results. Five of the nine groups said acceptable; three were opposed; legislators were split. Importantly, corporate CEO's and union leaders are together in leading the opposition.

Also, majorities of all groups said that having to obtain care as a member of an HMO is an acceptable compromise to attain cost efficiency.

As to the appropriate role of government in health system reform, respondents here felt overwhelmingly that the major initiatives will be necessary to reform the health care system, but the government's appropriate role was as a rule maker, not as the operator or manager of the system.

Now, while the debate over reform intensifies and frequently turns contentious, we believe, at Met Life, that these survey findings should prove encouragement to those who are seeking the needed consensus.

In summary, the survey showed that leaders believe change is needed. There is strong agreement among them that change is likely, and that it best be made incrementally.

And, importantly, there is the clear recognition of the necessity for compromise in order to create a better system for all Americans.

Mr. Leitman and I would be pleased to answer any questions you might have, and we thank you.

[The prepared statement of Mr. Moynahan appears in the appendix.]

The CHAIRMAN. Let me ask you to give me a little more detail on the question of tax deductibility on health insurance premiums. You say that corporate and union leaders join together in opposition?

Mr. MOYNAHAN. That is correct.

The CHAIRMAN. Is that right, Mr. Moynahan?

Mr. MOYNAHAN. Let Bob or I find the actual question and we can quote that to you and give you the reactions specifically.

The CHAIRMAN. Get a little more detail on that.

Mr. MOYNAHAN. It is not a surprising result, by the way, because of the——

The CHAIRMAN. All right. I understand. I understand.

[Laughter.]

Mr. MOYNAHAN [continuing]. History and so forth. Bob, can you locate that?

The CHAIRMAN. But I was listening to the testimony this morning on managed competition by Professor Enthoven. And, of course, he is talking about removing part of the deductibiiity. And I would assume you would have very strong opposition from union leaders and corporate leaders.

Mr. MOYNAHAN. You probably will. But I think we see a lot of interesting things in this survey in the way that the percentages are quoted here. We had the choice of absolutely in favor of, somewhat in favor of, somewhat opposed, and absolutely opposed, and so forth. And sometimes the percentage of the respondents who are closer to the middle becomes a very important consideration.

The CHAIRMAN. That is right. It reflects the intensity of the feeling, then.

Mr. MOYNAHAN. That is correct. Yes.

The CHAIRMAN. All right. Give me a better feel.

Mr. MOYNAHAN. Did you find it, Bob?

Mr. LEITMAN. Yes. This is the question of paying income tax on health care premiums paid by employers.

Mr. MOYNAHAN. Yes.

Mr. LEITMAN. Among the business executives, 40 percent found it acceptable; 59 percent did not. And the other dissenting group was union leaders, even a strong dissent: only 26 percent found it acceptable; 74 percent did not.

For example, among the government groups that we surveyed, about two-thirds thought it was a good idea. Among physician leaders, similarly, about two-thirds thought it was a good idea.

The CHAIRMAN. Of course, there are tradeoffs in all of these things. And if you are talking about trying to raise revenue, that is the other side of it, and pay for some of these things, particularly for some of these people that might not be covered under some of the plans.

In some proposals CBO estimated about 2 or 3 percent still uninsured; others they are talking about 5 and 7 percent. That would be one of the options you would look at in trying to determine how they would react to that. Everyone is for the benefits; very few want to pay for them.

Mr. MOYNAHAN. Yes. Well, I think, again, in this survey, as with almost every survey that will be reported to you, the question itself is quite a predictor of what the answer is going to be.

Now, in this context, we did not talk about the taxation of benefits above a basic level, which is the approach that is discussed by Dr. Enthoven. Had that question been put in that way, I am not sure what the final response would be today.

So, I think we need to take this in the context of the question itself. There is an attitude among employers and labor leaders relative to the sanctity, if you will, of employee benefits, as a tax-favored practice, in general, and whether or not they will be able to separate health from the rest of it is another issue.

The CHAIRMAN. Dr. Immerwahr, you were talking about trying to further educate people concerning these options, these choices, and what they mean.

Do you have anything in mind, other than what we have been doing, and do you have any idea as to what traps to try to avoid in getting that message across, to get clarity and understanding to the extent we can?

Dr. IMMERWAHR. I think what people do not respond to very well is being blitzed with a lot of different facts. People are, in a sense, already overloaded with new perspectives and so on.

I think that people do respond to choices—one, two, three choices—that are clearly laid out with the tradeoffs for the people who have to live with them. A very sharply focused debate around a couple, three choices, I think, will engage people more clearly.

The CHAIRMAN. Dr. Altman, how about you, do you have some ideas of how we can get this message across?

Dr. ALTMAN. I actually think that the single most important development that will help educate the public is not anything we do to educate the public per se, but rather the forward movement of the electoral process, as I said before.

I agree, people will respond to basic gut choices. When we get to a point where we have two candidates, one Republican, one Democratic, arguing perhaps philosophically opposed health care plans, then we would really have the opportunity, the enabling condition, to educate the public.

I hasten to add, though, that I think it is a mistake to believe that we will ever get perfect understanding or perfect information that would lead to a clear public consensus.

We are likely to wind up in a situation—as I said, even experts are divided—where difficult choices need to be made and sold to the public.

The CHAIRMAN. Well, I am sure you are right. We are not going to get total, 100 percent consensus. No question about that. I see my time is up.

Senator Durenberger.

Senator DURENBERGER. I need to ask you first, maybe all of you, what—I am glad Tom is here so I can use this phrase—Reischauer may have called an uninteresting question. The question is, why did you do these surveys? What is the point of all of this?

That question is phrased in terms of, do you think we ought to keep doing these things periodically, and, if so, should we be shifting our focus from time to time? And what do these surveys tell you about what are, perhaps, some of the questions you did not ask that might be more important to the process of reform?

Dr. ALTMAN. I cannot answer the second one without turning it around and asking you whether such surveys are useful to you. Because, from our point of view, that is why we do them, to try to establish a neutral benchmark or yardstick of where we are, how far we have gotten, how far we still have to go; to see if anyone's message on health reform is getting through and, if so, which message. In short, we are trying to paint the environment in which you all need to do your work and struggle with this issue.

So, that is why we do it. As to whether it is useful, I would have to ask you and a few Governors and others that question.

Dr. IMMERWAHR. We have been very interested in looking at public opinion—not as a static thing—but as a process. We see people go through a process on different issues.

I think health care is a very interesting example of that; we are now clearly in the consciousness-raising phase.

People are beginning to be aware of this as an issue; they are beginning to feel the pinch, they know people who do not have coverage.

But they are not yet on the phase where they have really understood the issue; they are not ready to make the tradeoffs and ask the hard questions.

This is one of those issues where it is very important to document where the public is now, if we are going to find a way to deal with this issue.

Senator DURENBERGER. Mr. Moynahan, the reason I ask the question is that it is sort of like, somebody around here a year or so ago coined the phrase, "$100 billion in administrative excess." And this morning we found out, at least if you believe Dr. Reischauer, it is probably closer to $10 billion. But it stuck forever. So, each time this wonderful data comes out, it gets to be somebody's speech material. That is principally the reason I asked the question.

Mr. MOYNAHAN. I would like to respond to it. Met Life, as you realize, is a major stakeholder in the national health care system.

We realize that we have significant problems and we think that they need to be resolved in the interest of all of our insurance carriers who participate in this system.

What we are hopeful that this survey would help to do is to contribute to a data base that would help the deliberations move forward in a more accurate, and, in the end, successful way by opening the view to where there might be compromise; how we might find ways, if you give this up and I give this up, we might have something that works. We felt this needed to be discussed, and we hope that this kind of survey will help that process along.

Senator DURENBERGER. And I think the near unanimity of your response is very, very helpful to me as a policymaker. I happen to share the view that the public, when faced with wanting to have more but having to pay less for it, is going to find somebody else to blame.

That is sort of a natural thing, somebody else to point to in this system. And as long as they do not have a vision of some kind as to where all of this is leading, is it going to be very difficult for them to say, I will tighten my belt a notch if they do not see everybody else doing the same thing.

Maybe you can tell me the answer to this. What we seem to be getting out there is a lot of, you know, the greed response, or whatever it is, sort of anecdotal information is coming back.

We are not getting anything that goes very deep into what people's real values are, or, as one of you said in the response, as we look ahead, what do we want to hang onto the most and what are we willing to give up first, and some of those sort of values-related issues. We do not seem to be——

Dr. ALTMAN. Senator, we are seeing one change which is important and should be mentioned in response to that point. In the past, we have often found that people are for changing the generic system, but don't want their individual medical arrangements changed. And that really is part of the tension that you are talking about.

But, now, in just the last 5 years in this survey, we have seen a doubling in the number of Americans who are dissatisfied, not just with the generic system, but with their own personal medical care. It is still a relatively low number, but it has doubled from 13 percent to 26 percent. One can speculate as to what would happen if it doubled again and what the effect of that would be on the health reform debate if it doubled again in the next, say, 5 years.

Senator DURENBERGER. Mr. Leitman?

Mr. LEITMAN. Well, I just feel, on behalf of Louis Harris and Associates that I ought to say that one can never do enough surveys. [Laughter.]

But if I could just indulge you for one second. Both Mr. Moynahan and Mr. Altman, when they came to us, were very careful about saying, how can we make a contribution here, what can we document here.

Senator DURENBERGER. Yes.

Mr. LEITMAN. There are threads that run through the results of both of their surveys which were done totally at different points in time and totally separately: the consensus about the need for change; about the need for universal coverage; about the need for costs to be controlled; about government having to take action, about the Federal Government being the level at which that action has to be taken; about the lack of consensus about precisely which choice, which plan would be the best, but the need for one of them to emerge over the course of the debate; about willingness to move towards more managed care by both stakeholders and the public; and a general concern about the costs being borne by somebody else.

Whomever you ask, there is a sense that somebody else ought to bear the cost. And, if I could add one more thing, there is also the issue of real experiences.

One of the things the Kaiser/Commonwealth study also documents is that there are impacts on people's lives that are documented throughout that are, in some ways, embodied in the questions that are in Mr. Moynahan's survey. Those points, we would like to think, at least help move us along and tell us what is left to be answered.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. I am sorry I was not here to hear your testimony, but I would be curious if you could

enlighten us to a certain degree as to public perception of the government versus the private sector. Is there a general comfort level with one or the other that is evident from your polling?

Dr. ALTMAN. We asked that question very, very directly, and you will have that data in the record. We asked, who should take the lead in solving the problems with our health care system, and the result was overwhelmingly clear: not only government, but the Federal Government. Not the private sector, not State government, but clearly the Federal Government.

In fact, only 3 percent thought health care reform should be a shared Federal and State government responsibility. On the other hand, I suspect this has more to do with who should take the lead than it does with who should run the system, and that question we did not ask as directly.

Dr. IMMERWAHR. I wonder if I could amplify that a little bit.

Senator DASCHLE. Yes.

Dr. IMMERWAHR. What we see, especially in focus groups is that people think that government is pretty good at regulating, and controlling, and stopping people from doing something wrong.

When you say to people, "what should we do about this health care cost crisis," they say, "well, somebody ought to get in there and control it, and just stop them from raising these prices." In contrast, people think government is pretty bad at providing services; they think government is wildly inefficient, and so on.

What pools are picking up is the view that government can help control the cost explosion, but more skepticism about whether government could actually provide health care.

Dr. ALTMAN. We had a new finding on this point in our poll. In recent years when we have asked, who do you blame for the problems with our health care system, it has been a horse race between doctors and insurance companies, with hospitals coming in third.

For the first time in this poll, it was a close race, still, but government came in first in the blame game. This says a lot not only about where people are expecting leadership to come from, but who they hold responsible and what level of public/Federal officials they hold responsible for solving the problem.

Mr. MOYNAHAN. There was a very pointed response in the survey of leaders, Senator, who were asked the question, if government takes over the management of the health care system, will things get better? And we also asked what would happen to costs if the system was reformed overall.

In this survey of leader's opinions—this is not the general public—72 percent of the 2,000 surveyed leaders said that the costs would be higher under a federally-run program, and 67 percent of them felt that the quality of the system would be lower than if it were done through an expanded private-sector/public partnership program.

Interestingly, Federal legislators, 58 percent of the 260, I think, that were surveyed, were convinced that costs would be higher; 60 percent felt the quality would be lower. Interestingly also, of Federal regulators, 73 percent believed costs would be higher, and 53 percent felt the quality would be lower.

There was a pretty consistent run through the entire program, save union leadership, who holds their traditional view that a sin-

gle, national government-run program is their choice. All the other surveyed parties felt that costs would be higher and quality lower.

Senator DASCHLE. Let me ask a similar question. I think I may know the answer, but I still think it would be helpful. If the amount to be paid into the insurance system were the same, have any of you asked if there is a preference for that payment to be made in the form of a premium or in the form of taxes? Do they differentiate between the two if the amount to be paid for the product is the same?

Mr. MOYNAHAN. Well, in our particular survey that specific question was not asked in just that way, and I would hesitate to try to interpret some of the other questions to bring an answer.

Senator DASCHLE. I see.

Mr. MOYNAHAN. That would need, I think, a very focused question to get a reliable response. I do not know about the other survey.

Senator DASCHLE. Based upon any of the data that you have, would you care to make any guess at this point? It is dangerous to guess on something that fundamental.

Dr. IMMERWAHR. Well, there is a great deal of suspicion, as you know, about taxes and tax increases—taxes always go up; they never come down; they get lost in government bureaucracies. So, many people might think that their money would be better spent in a premium. But I do not have any hard numbers on that for you.

Mr. MOYNAHAN. My sense is, and I think it is evident in this survey, that there is a recognition among leadership that, to solve a great deal of the problems we have, taxes may come into the picture as a necessary part of the solution. Also, that we will need to do something about premiums as well, and bring those under control.

Senator DASCHLE. Well, I have seen reports of polling data that suggests that people are wiling to pay higher taxes for effective cost control and for a better system.

And I do not know the degree to which that is uniform in all the polling data, but there does appear to be a willingness on the part of many to sacrifice their current situation in order to obtain more certainty in the system in the future.

Dr. ALTMAN. We did ask how much people were willing to pay. I cannot tell you whether they would prefer to pay it in a tax or in a premium.

In fairly conservative New Hampshire, for example, in our post-primary poll there, we found that enough New Hampshirans were willing to pay enough money that, if the rest of the country looked like them, it would finance a $20 billion program. So, you can make of $20 billion what you will.

Mr. MOYNAHAN. Yes. I think in our survey it was clear, the question was specifically asked, if it is going to take an increase in income taxes to solve the problems that we have in the system, would you be willing to pay it? And the answer was yes, in the majority. They would have some understanding that we were not talking about $50 a year, or $100 a year.

Senator DASCHLE. Very well. Thank you. Thank you all. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Well, thank you, Mr. Chairman. Dr. Altman, your survey indicates that 26 percent of Americans are somewhat dissatisfied or very dissatisfied with their health care, but the flip side of that is that three-quarters of Americans, according to the same survey, are satisfied with their health care.

Now, that being the case, do you think that most citizens would want to make major sacrifices, such as reducing their benefits or increasing their premiums, that health care reform might entail? And are the American people really in a position to want major changes now?

Dr. ALTMAN. A key question. It is important that some 75 percent of the public are satisfied with their own medical arrangements. But let us be clear about what that means and what they are still dissatisfied with. It means that most are happy with their doctors and their hospitals, and with the nature and quality of the care that they get. In the case of 25 percent of respondents, they are not happy about these things and, if I may reiterate, the proportion of unhappy people has doubled in the last 5 years.

However, when we ask about money and how much they have to pay in health care costs, we get an entirely different picture. Even though they could be satisfied with their doctors and hospitals, fully 82 percent of the public express some significant concern about their health insurance costs. Americans are more worried that they will not be able to pay their medical bills than that they or their spouse will lose a job in the middle of this recession.

Moreover, this fear of costs is pervasive—rising far up now into the ranks of the middle class and the insured. That is really the change we see in this survey. Access to affordable health care is no longer just a problem for the 34–37 million Americans without insurance. That leads me to believe that there is greater support for change than the 25 percent number would, by itself, suggest.

Senator HATCH. Yes. I would think that is right. Dr. Immerwahr, go ahead.

Dr. IMMERWAHR. Well, I think that the momentum for change is stalled by a perception that there is an easy solution.

If you say to people, "well, I think you ought to have less choice or wait longer for tests," and so on, their thinking is, I should do that when these costs are going up like crazy and when it is all going to malpractice attorneys? Why should I wait longer for an important test so a malpractice attorney can make more money?"

Senator HATCH. Sure.

Dr. IMMERWAHR. So, in other words, many people now believe that there are solutions that will not affect their health care delivery, but will only cut into the public——

Senator HATCH. Yes. My experience is that people really do not fully understand the problem. It is a national problem under consideration and they generally demand a Federal solution. And they think the Federal Government can solve all problems because we can do it for all 50 States.

If they do understand the problem, and apparently they do not here because they are all pretty well coming out equal in whichever plan you put up there, then they demand a private-sector solution or a State and local solution much more than they do the Federal solution.

But, Dr. Immerwahr, just reconcile the statement that, "Most Americans believe we have a health care profits crisis, not a health care cost crisis," with the data just presented by Dr. Altman's testimony suggesting that rising health care costs were of concern to Americans across all income strata.

Dr. IMMERWAHR. That is absolutely the case.

Senator HATCH. It is.

Dr. IMMERWAHR. But, if you ask people to diagnose what is going on, they say, what is going on is the profits are going up so quickly. In other words, it is not that health care somehow costs more to delivery or is more expensive; it is just that people are taking a bigger slice of it.

Everybody has a different villain. Older people point the finger at drug companies; low-income people at doctors; middle-income people at malpractice attorneys. But they are all convinced that the money is going somewhere other than health care benefits.

Senator HATCH. Well, let me ask Mr. Moynahan and Mr. Leitman, based on your interpretation of your survey, do you think Americans are now ready to make major changes in their health care delivery system?

Mr. MOYNAHAN. Yes.

This is the leadership group that we talked about. One of the findings that came out of this was that there was a virtual consensus agreement that the system needed to be changed and it needed to be changed in significant ways.

Senator HATCH. Are they prepared to live with whatever the changes are?

Mr. MOYNAHAN. That depends on the tradeoffs and choices, Senator.

Senator HATCH. What might the changes be?

Mr. MOYNAHAN. Exactly. And I think one of the things that did come out through this, however, is that I think there is less of a desire for what you might call comprehensive heroism than there is for urgent incrementalization in finding a solution.

Senator HATCH. Let me just say this. What do you find to be the major consistencies and inconsistencies between your study and the Kaiser study? It seems to me that the tone of your statement seems to be much more optimistic—if I am interpreting right—for the prospects of affected parties making necessary tradeoffs than the data in Dr. Altman's survey which indicate that there is a great ambivalence among the American people over which precise direction should be taken.

Mr. MOYNAHAN. Well, again, we are talking about two entirely different groups.

Senator HATCH. Right.

Mr. MOYNAHAN. So, you might expect that their response to this would be different. I think, again, we believe that the audience that our survey addressed and asked questions of might have a better understanding of some of the things that are at play here and they might realize more intensely that they are going to have to make some adjustments.

So you might find a more optimistic response, because you are also aware that if they do not move in some direction something

that they do not like will probably happen to them. It is better to have a small trade-off than a major disaster.

I think one of the things that does seem to come clear—I do not know whether Dr. Altman would agree with this, or not—there does tend to be an urgent sense that government should be the major player in finding the solutions to the problems that we have. That was in our survey, and it obviously was in the Kaiser survey.

Whether governments should be the final, ultimate, and all-encompassing solution, there seems to be an indication among other surveys that that is not broadly held. Even when you talk to pay-or-play, which seems, in some surveys, to be an attractive and willingly accepted alternative, because it seems to be a middle-of-the-road.

If you take some discussion of the Urban Institute study and the NFIB analysis that also points to play-or-pay being somewhat an irreversible move down the road to a government-run program, you might get a very different answer if you see what the end result is.

So, again, the questions here need to be very carefully analyzed before they are weighed terribly heavily.

Senator HATCH. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Altman, in your survey, as I understand it, the public feels very strongly that you should have government intervention on prices for medical care, for the services, and 70 percent, in effect, support price controls.

Dr. ALTMAN. 75 percent. Yes.

The CHAIRMAN. 75 percent.

Dr. ALTMAN. Yes.

The CHAIRMAN. Is there a difference in how they feel toward other goods and services, insofar as price controls?

Dr. ALTMAN. Bob Leitman may know the answer to that. I have not looked at those comparisons.

Mr. LEITMAN. I can tell you from other work that has been done. I will give you an example. A survey of 7,000 members of the public asked about value, where they thought they had good value and bad value.

There were five health factors in there—hospital charges, doctors' charges, insurance, dentist fees, prescription drugs—and they all came down very, very low on the list.

So, I take that to be a very serious indicator that people think relative to other goods and services in this list of 50, which was very comprehensive, that health care is not seen as good value for the dollar. And that leads to some of the other findings that were discussed today.

Again, Americans' understanding about why costs are what they are is very thin, but, clearly, we do not believe, as a country, that at this point we are getting good value for our money.

Dr. ALTMAN. Senator, I think the most honest answer I can give, thinking about all of the responses we get in our surveys, is that people are desperate for some solution to the cost problem that they are feeling, period.

The CHAIRMAN. This is the one that is hurting the most.

Dr. ALTMAN. That is the one. And we know what is worrying them about cost. It is concern about their own payments for insur-

ance and out-of-pocket payments, and also fear that their benefits will be cut, or their dependents' coverage will be eliminated because it costs their employers too much.

People seem to express a preference for government intervention to control health costs, that is the 75-percent number. But there is also strong support for other approaches.

For example, now we see a majority of Americans saying that they would be willing to accept managed care, that is to accept some limitation on their freedom to choose doctors and hospitals in exchange for lower costs.

So, the best interpretation I can give you is they want a solution to the cost problem, period, and are open, at this point, to a variety of approaches.

Mr. MOYNAHAN. If I may just add one thing to that. Again, this goes to the value of the surveys. Some of the surveys put forward an almost irresistible fix in terms of describing price setting, and it seems to assuage the pain that most people feel. It is the white hat going after the black hat, in a sense.

But very few of the surveys, to my knowledge, discuss the price that you pay for price fixing. I am not sure how the response of the public would be if they had a full discussion and full disclosure on that in some of the focus group kind of organizations.

The CHAIRMAN. I wonder if the words "price controls" were used in any of the questions? Price controls have some connotations sometimes.

Dr. IMMERWAHR. In focus groups, people say it spontaneously. You see, a simple problem calls for a simple solution. In a sense, for most people, the problem is the prices. People do not understand that technology is driving the cost up, because technology in the rest of their lives, makes things cheaper. It is a complex argument. Since they think it is prices that are out of control, that is what they think needs to be controlled.

The CHAIRMAN. All right. Do you have any further questions?

Senator HATCH. Could I just ask one other question? In your surveys, and in your discussions and your studies of this, did you come to any real definitions of what the major and minor changes they want would be?

Is it like universal care, single-payer, play-or-pay, or is it basically just one idea or another idea considered as major changes? For instance, medical liability reform, or lower costs, or better insurance, or whatever?

Mr. MOYNAHAN. Well, I will start on that, if you want. I think at the time our survey was done, there was not as much clarity, supposedly only three alternatives were being considered. So, there was no question put in that.

Senator HATCH. Well, it is apparent that they do not understand those alternatives either. They basically think they might be answers, but they do not fully understand what they mean.

Mr. MOYNAHAN. I think today, even, that is true. I think there was clarity, in our survey, at least, that the issue of universal access to financing and care was a major problem that they agreed needed to be solved.

There was a clear indication, in their view, among all of these leaders, of the importance of managed care as a private sector al-

ternative and method to approaching the exchange of quality and cost in a controlled way.

There was, I think, a general agreement—and, Bob, you may want to add to some of this—that, importantly, there was going to be something done about both the access and the cost issues and that they would want to participate in a cooperative way in finding a solution. Those are the major things that came out of ours.

The CHAIRMAN. Well, thank you very much, gentlemen. We appreciate your contribution.

Mr. LEITMAN. Thank you.

Mr. MOYNAHAN. Thank you.

Dr. IMMERWAHR. Thank you.

Dr. ALTMAN. Thank you.

[Whereupon, the hearing was recessed at 2:40 p.m., to reconvene on Thursday, May 7, 1992 at 9:40 a.m.]

COMPREHENSIVE HEALTH CARE REFORM AND COST CONTAINMENT

THURSDAY, MAY 7, 1992

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to recess, at 9:40 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Present: Senators Baucus, Pryor, Riegle, Rockefeller, Daschle, Breaux, Packwood, Danforth, Chafee, Durenberger, Grassley, and Hatch.

Also present: Senator Paul David Wellstone.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. If you will please cease conversation, the hearing will be under way. Today we continue our examination of the proposals for health care reform with a focus on the increasing and alarming growth of health care costs.

The figures are quite familiar by now. Health care spending is higher in the United States than any other country in the world, spending approximately $850 billion; 9.1 million people directly employed in the health services sector of the economy. Health care spending is estimated to be 14 percent of the GNP this year. Dick Darman, over at OMB, projected it to be over 17 percent by the end of this decade, and that is an unsustainable figure.

If you look at it as a single snap shot in time, it is not so disturbing. But, what is of concern is, as stated by the CBO Director yesterday, the trend line and where it is going.

In 1984, national health spending was half of what it is today. By the end of this decade, it will double again. If we continue, we will be spending $1.6 trillion by the year 2000.

So, more and more Americans are finding health care unaffordable. We have the finest health care system in the world for those that can afford it, but less and less accessibility because of cost.

Small businesses, are forced to increase the deductible, then they increase the co-insurance, then they drop the dependents, then they drop the policy altogether because they simply cannot afford it. There are 34 million Americans without health insurance; 12 million of them are children.

We can see the implications of this trend in the Medicare and Medicaid programs, over which this committee has jurisdiction.

The Congressional Budget Office projects that Federal spending for these programs will total $350 billion in 1997. That is more than twice the spending level of 1991.

In recent years, we have taken some steps to try to slow that trend in growth. The Medicare program has been a leader in the use of DRG's for the hospital payment; RBRVS for physician payments; and other mechanisms for cost containment.

The most recent effort for further restraint in Medicare and Medicaid spending was the amendment offered by the Ranking Member of the Budget Committee on April 10.

That proposal originated in the President's fiscal year 1993 budget and would establish caps on entitlement spending. It sounds like a simple answer, a simple solution.

I opposed that amendment for several reasons. Chief of them is my concern that we can not slow growth in health care costs through restraint in Federal program spending alone.

Deep cuts in Medicare and Medicaid will just shift the costs. The providers will shift those health care costs to privately insured individuals, businesses, State and local governments already struggling to maintain health coverage.

The job for us is to look beyond that and the increase in health care costs themselves and try to address it. Today, we have a number of witnesses to help us examine approaches to improve our ability to contain those costs: Kevin Moley, Deputy Secretary of HHS, will present the administration's proposals to contain growth in health care expenditures.

AFL–CIO President, Lane Kirkland, will provide organized labor's perspective on controlling growth and health care costs.

Dr. Stuart Altman will offer his views as a widely respected authority on health policy. Deborah Steelman will report on the recommendations of the 1991 Advisory Council on Social Security, which she Chaired, for controlling health care costs. We will also hear from representatives of health care consumers, providers, and businesses.

Most Americans agree that health care costs are way out of hand. Every survey we saw or heard about yesterday from the witnesses said they are looking to us, they are looking to the Federal Government for action. We are going to be looking forward to hearing from our witnesses for their insights as we tackle this problem.

I would ask my colleagues to limit their opening statements, if they have any, to 3 minutes, because we have some very excellent witnesses we want to question at some length. We want the time to do it. We have an order of arrival here.

Senator Hatch.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman. I appreciate you holding these hearings. I think they are critical to this discussion and I will look forward to listening to all of the witnesses today, because all of us are concerned about the meaningful reform of our health care system and the rate of growth of health care costs. And I would ask that the balance of my statement be placed in the record.

The CHAIRMAN. That will be done. Thank you.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. Senator Riegle.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN

Senator RIEGLE. Thank you very much, Mr. Chairman. Let me thank you, again, for your leadership in this very important area of national urgency. If I may, in the time that I have, I want to just review quickly the record for the sake of our first witness.

Back on December 13, 1989, I wrote a letter to President Bush setting forth a desire on my part to work with him and his administration to try to develop a comprehensive national health insurance program that could control costs and provide access to all of our people.

I got a routine acknowledgement from the White House that the letter had arrived about a week later. Then, 5 months later, I got a detailed letter from Secretary Sullivan indicating his concern. That was dated May 10, 1990.

I had an opportunity then to meet with the President on June 13, 1991, and I raised the health care issue with him in his office. And I talked about the case of a young woman in Michigan, named Cheryl Eichler, who died of Crohn's Disease, whom I think would be alive had she had health insurance and care; a woman about 30 years old.

And I did so because the President, I knew, was familiar with Crohn's Disease, a very terrible medical problem, because he has a son, sadly, that has a similar problem.

And I urged him at that time to work with me and others in the Congress on a bipartisan basis to do something about the urgent need for a comprehensive national health plan of one kind or another that could control costs and get coverage out there to our people, coverage that they could afford and which did the job.

He suggested that I meet with Secretary Sullivan. I established such a meeting. We met, then, on November 5, 1991. Now, a lot of time has elapsed, of course, over that stretch of time. I had a good discussion with Secretary Sullivan. He was interested in the topic, and so forth.

But, I must say, as we meet here today, there is still no comprehensive plan from the administration, there is no legislative package that deals in a comprehensive way with cost control and the issue of access; how we get insurance coverage to those that are now losing it, families that cannot afford to maintain it because the costs are going up so fast, or the 40 million or so people in the country that have no insurance at all. We have 1 million of those in my home State of Michigan, 300,000 of which are children.

And I could cite, if I had the time, many examples of just terrible human hardship, suffering, and death, in fact, because of an absence of health care.

I do not think that doing nothing or doing a little bit around the edges really addresses this problem. I hear this talk that there is not a consensus. There are a lot of times in the country when, on

a difficult issue, there may be various options for approaching it, there may not be initially a consensus.

That is a time, as I see it, for leadership. I think the reason we have elected leaders, particularly a leader of the executive branch of government, is to give the leadership to help break the impasse and to move us down a path towards a comprehensive plan that accomplishes these two goals.

So, I will just finish by saying that I feel that I have to have, as a U.S. Senator and as somebody running a Health Subcommittee, a comprehensive plan from this administration in legislative language that addresses this problem from start to finish. We do not have that now, and I would like to know when we will have it. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley, do you have any comments?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you, Mr. Chairman. Some of our witnesses today are going to emphasize, as health care spending heads towards 30 percent or more of our gross domestic product, that the standard of living of our people is going to decline and our international competitive position will erode. And I think we all agree that we cannot tolerate this state of affairs any longer.

Now, at the same time, most of the projections that even Senator Riegle refers to are based upon rates of growth in health care spending that we have experienced for more than a decade.

I certainly agree with a number of my colleagues on the committee who have observed that breaking this health care spending habit is going to be very difficult.

In fact, I was taken by a point that will be made by one of our witnesses today to the effect that necessary changes are really of an unprecedented magnitude.

What other parallels in recent American history can we think of which entail the kinds of drastic revisions in an established institutional sector that are being called for in the health care sector today?

Probably not the establishment of the Social Security system; probably not the establishment of Medicare, nor the 1982–1983 rescue of the Social Security system which was really something of a crisis requiring an unprecedented Congressional/ Presidential national commission to solve, and I suppose we could go on and on.

In any case, Mr. Chairman, we need to start moving, and I hope that these and the future hearings you have scheduled on this issue will help us find a way out of what is a very difficult thicket.

The CHAIRMAN. Mr. Secretary, we are pleased to have you. I must say we were disappointed we did not get your statement, I understand, till last night. It would be most helpful if, in the future, you would give us a little prior notice so we can have a chance to examine it and perhaps ask a bit more informed questions. Or, perhaps that is not the way some would like it.

I understand we are receiving from Treasury the first phase of some of the details that the President is suggesting.

So, if you would go ahead, Mr. Secretary, we are pleased to hear your statement. I would ask that you try to limit it to 10 minutes so we will have an opportunity to ask questions.

STATEMENT OF HON. KEVIN MOLEY, DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Deputy Secretary MOLEY. Indeed, Mr. Chairman, I would like to ask that my full statement be entered in the record, and, that I be permitted to paraphrase, in the interest of the committee's time.

The CHAIRMAN. That will be done. That will be done.

[The prepared statement of Deputy Secretary Moley appears in the appendix.]

Deputy Secretary MOLEY. Mr. Chairman, members of the committee, I am pleased to be here this morning to talk about health care costs and how to contain them. This issue goes to the heart of any serious approach to health care reform.

The President's Comprehensive Health Care Reform program offers an effective response to this issue, one that is compatible with our American culture and expectations for a top-quality health care system.

We are all familiar with the numbers that document increasing health care costs. The unsettling implications of those numbers is that the rate at which health care costs is growing is unsustainable into the future. Health care costs have been increasing at two to three times the rate of the rest of the economy.

No segment of our economy is immune from the effects of this, as we witness expenditures on health care consuming more and more of our resources each year. Workers face lower wages than they would if health care costs were lower; individuals face stiff premium increases and growing out-of-pocket costs.

Federal and State Governments find health care their biggest budgetary problem. The portion of our economy devoted to health care increasingly squeezes our nation's resources and ability to support other important priorities: housing; education; and infrastructure; all priorities that are essential to sustain and improve our current standard of living.

The Secretary has said repeatedly about health care spending that, "It seems that the $2,700 spent on average for each and every man, woman, and child in this country ought to be enough." This is more than any other country in the world. Yet, despite this expenditure, more than 13 percent of Americans are without any health insurance at all.

The President's Comprehensive Health Care Reform program, announced February 6, carefully builds an approach to health care reform that meets the twin challenges before us: expanding access and containing costs. Parts of this program are reflected in the bills that we will transmit this week and in the weeks ahead.

The President believes strongly, after considering the consequences of the alternative, that cost containment can best be achieved through restructuring incentives and creating a market-based system.

A market-based system allows and promotes consumer choice, both choice of providers and of delivery systems. It further allows flexibility in coverage and benefits, fosters innovation, and allows

more decentralized and individually-based decisionmaking through multiple local payers, providers, and consumers.

Any alternative that is premised on substantial government control of choice, price, or other aspect of the health care system through a centralized regulatory system will never control costs effectively, nor be compatible with American values.

In developing the framework for our program, the President chose to build on what is best in the existing system and reform what does not work. We will strengthen and empower purchasers to make better informed choices.

To contain costs, the President's program creates market-based incentives, removes barriers to efficiency within the system, and controls cost drivers. The President's cost containment provisions should each have a positive influence on costs.

In addition, the President's program obtains greater leverage from the provisions because they are designed to interact in a way that heightens the incentives to control costs and thus achieve an even greater savings impact.

I would like to submit for the record a 56-page analysis of cost containment benefits from the President's program that has just been recently developed by the Health Care Financing Administration and others in our Department and the administration.

The CHAIRMAN. That will be done.

[The information appears in the appendix.]

Deputy Secretary MOLEY. The proposed initiatives in the President's program to make insurance more affordable and accessible will result in millions of new consumers; individuals and small businesses, looking in the marketplace for and expecting to purchase affordable health care.

This sets in motion the market force for a cost containing, competitive health care system. Consumers will be looking for value in the marketplace.

Many providers and insurers will want to serve those better informed consumers. Insurers will do so, because with the President's private insurance reforms, insurers will no longer be competing on the basis of insuring only the healthy. They it will be competing on the basis of cost containment and quality.

As a result, we can expect that services provided and benefits offered will be responsive to the consumer's preferences and needs.

What the President has proposed will empower the consumer, through choice and competition, to influence the local market toward cost containing action rather than create centralized bureaucracies that revert to price controls and global budgeting.

To add impetus to the incentives, the President's program would substantially increase consumer information, and remove the barriers to cost-effective choice involved in coordinated care systems, which are well-recognized for their high quality and high value.

The use of coordinated care systems is one of the best ways to reduce fragmentation of services and excessive use of services, and is a centerpiece of the President's program.

In tandem with these initiatives, the President's program also launches reform initiatives that target "cost-drivers," such as malpractice and administrative inefficiencies, which spur on the inflationary tendencies of our present system.

The final cost containment feature I want to mention is the powerful potential of better primary and preventive care. These activities give us the best of both worlds. They improve health and enhance quality of life, and they also contain costs. These are things that we can do for ourselves that vastly improve our quality of life. They will also save health care costs.

In conclusion, these actions will contain costs by restraining the inflationary elements and inefficiencies in our current system.

I believe the President's Comprehensive Health Care Reform program offers an approach to cost containment that would be acceptable and compatible with American expectations and would ensure that we do not undermine the high-quality, acute care system we now have. Mr. Chairman, thank you.

The CHAIRMAN. Well, I admire the brevity. Mr. Secretary, on pages 4 and 5 of your statement, you argue that the President's plan will reduce costs through two approaches. First, that you say that the insurers and the providers will compete for that new business for the uninsured.

And, second, you argue that the insurers will be competing on the basis of cost containment, as I heard you just a moment ago, and quality, rather than trying to avoid unhealthy individuals.

Well, let us look at the first point you made. Simply covering the uninsured will lower health care costs. If that is true, why does the President not come out for universal coverage as a way of lowering costs even more?

Now, Bob Reischauer, who is the head of CBO, in testifying yesterday, said expanding coverage through a tax credit plan as proposed by the President would actually increase the costs by approximately 2 percent.

Why do you believe it would lower costs? Get a little more specific for me on this competition. How is it going to change from what we have seen thus far?

Deputy Secretary MOLEY. Mr. Chairman, as you know, we have estimates of over 34 million Americans, our fellow citizens, who are without health insurance. They are, however, not necessary without health care.

Unfortunately, very unfortunately, as you know, those without insurance often wait until they are too sick, and show up too late at the costly back door of our system, the emergency room.

Our Inspector General has Medicaid statistics saying that anywhere from one-half to two-thirds of those Medicaid emergency room visits are unnecessary in terms of being emergency-room-type visits.

The CHAIRMAN. There is no question about that. I have just been to visit several of the trauma centers in Texas. Time and time again we saw that people arrived there who would have had better and less costly treatment if they had not had to go through that process.

Deputy Secretary MOLEY. Indeed. And, in fact, those emergency room visits, as we now know, cost us anywhere from three to five times as much. And we all pay for those emergency room visits, since our private health insurers are subject to substantial cost shifting.

We pay for them in our public system, specifically in Medicaid, by virtue of their not having the benefits of coordinated care. But, more importantly, we pay for them through disproportionate share payments in both Medicare and Medicaid, as well as the 28 cents on every dollar that is spent by private insurance through cost shifting.

The CHAIRMAN. I think I agree insofar as the increased costs on the individuals that arrive at the trauma center and who should have been taken care of in more normal procedures.

But the other side of that coin is that, as Bob Reischauer testified yesterday, the uninsured use only half the services that the insured do. Therefore, they are getting medical attention at other points, and this adds up to even more. You might double or triple the cost for the few that finally get to the trauma center. But, he argues to the contrary in the overall picture.

Deputy Secretary MOLEY. Mr. Chairman, as I said earlier, a lot of our proposals are interactive with respect to cost containment. We are proposing to transition into the tax credit, the voucher, if you will, those monies that we currently spend, the discrete Medicare and Medicaid payments for disproportionate share, as well as those costs that are in the system through cost shifting and costly and unnecessary emergency room visits in Medicaid.

This will allow us to provide preventive and primary care for people to get them through the "front-end" of the system. Clearly, we believe that it is less expensive to treat these people in the "front-end" of the system than it is in the "back-end" of the system.

And I think it merely suggests that if we are to believe the rhetoric that many, if not all of us, have repeated for years, an ounce of prevention is worth a pound of cure. Through a number of different vehicles—the expansion of community health centers, the expansion of the National Health Service Corps, the reforms through RBRVS we are making primary and preventive care more available and accessible to virtually all of our citizens. There are tremendous cost savings to be accrued if we are to do so.

The CHAIRMAN. Well, I cannot help but think when you talk about preventative care how tough a time we had getting the administration to support the increases we needed in immunizations.

Let me get to the second point that you make, that insurers have been competing trying to cover only healthy individuals rather than by managing health care costs.

Well, as you probably know, I proposed legislation to try to address this problem in the small group insurance market. I am complimented by the fact the administration has chosen to adopt a number of those in their legislation. But I think that the health care cost problem is much bigger than that.

Later today you are going to hear a witness from General Motors talk about the problems they had limiting increases in health care spending for their workers. They are spending over $900 per car to provide health benefits.

I look at their competitor coming in, the Japanese, and starting new plants with much younger workers, with fewer health problems at those ages, and having a very substantial competitive advantage.

But I am listening to similar stories from CEO's across the country. One of last year's witnesses, Michael Peevy, CEO of Southern California Edison, felt so strongly, he sent us a statement for the record today calling for a Federal Health Care Board to set expenditure targets for national health spending.

Those businesses are not excluding the unhealthy workers. They are even trying managed care but they are simply finding it impossible to afford the increase in health care costs. Now, what does the President propose for them?

Deputy Secretary MOLEY. Mr. Chairman, we face a dysfunctional market—the lack of a market, if you will—in the purchase of insurance. And we have adopted many of the ideas that you proposed in small market reform.

And, in fact, we will be sending legislative language to the Hill later today on both small market reform and Health Insurance Networks.

I specifically draw attention to Health Insurance Networks, because I think you are absolutely correct. Merely dealing with the small marketplace through rating bands, as much help as that may provide does not go far enough. The fact of the matter is, we believe very strongly that we need small employers to have the opportunity to band together to purchase insurance with the same kinds of cost efficiencies that are available to larger companies, those that are ERISA-exempt from State mandated benefits. This provides them with the opportunity to have much, much lower administrative costs, which consume up to 40 percent of the premium dollar for small employers.

We agree that there are a number of reforms that are essential—fundamental reforms to the group insurance market—that are essential if we are to maintain a private sector that can provide health insurance for the majority of our citizens.

We have a situation right now, quite frankly, in which small employers oftentimes have disproportionately low rates if they have favorable demographics, for example an employee population, if you will, that looks like the 1992 Olympic Swimming Team.

But, as soon as one of those individuals or a member of their family becomes chronically ill, we see a circumstance where their rates go through the ceiling.

The reforms that are in your bill, and that are in our bill, do a lot to alleviate that problem. But they will not get to the root of the problem, in my opinion, unless we allow those small employers to band together, purchase insurance, and make deals with providers in the same sense and in the same way that large employers are doing increasingly across the country.

The CHAIRMAN. My time has expired. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman. Mr. Moley, I have read with interest the President's plan. And I was wondering if you could elaborate on the concept of HIN's (Health Insurance Networks).

Professor Enthoven, for instance, was here yesterday and he talked about HIPC's, or Health Insurance Purchasing Cooperatives. And I believe that his plan only works because his health care system is mandated and would be universal. And then, of course, the President's plan is not.

Therefore, can you identify for me the principal differences among the concepts of HIN's, HIPC's, and MEWA's, or Multiple Employer Welfare Organizations.

Deputy Secretary MOLEY. Let me first say that MEWA's, about which there has been considerable controversy, in and of themselves need reform. These Multiple Employer Welfare Associations, some of which have been self-insured, have, in fact, been subject to a great deal of fraud and abuse. We will be sending up in the coming weeks, very shortly, a MEWA reform package.

HIN's, Health Insurance Networks, not to be confused with MEWA's, will be insured entities. And, in fact, they already exist in many instances.

What we are talking about are associations, many of which are headquartered in this city, or which exist across this country—Chambers of Commerce, or industry-wide associations of small retailers. They would now have the opportunity to band their membership together for the purchase of insurance, having the economies of sale that large companies do, and being exempt from State-mandated benefits.

For instance, in the State of Virginia, add 21 percent to premium costs for small employer. In Massachusetts, 17 percent. In the State of Maryland, 15 percent.

It also would give them protection from the extraordinarily high administrative overhead costs that are associated with small employers; oftentimes those premium costs, 40 percent of which are for administrative costs, not for paying claims.

If we were to eliminate medical underwriting, the redlining of risk, going back to the dictionary definition of insurance, that is, the pooling of large numbers of healthy, unhealthy, young, and old, protecting them from pre-existing condition limitations, at the same time protecting the entity, the purchaser, the Health Insuring Network, from the extraordinary high cost of administrative overhead and from State-mandated benefits, we believe we would go a long way to creating a marketplace.

These HIN's would not be doing business as usual. They would demand deals from providers. They would demand the same kinds of arrangements that increasingly we see large corporations and their insurers entering into with provider networks.

Senator HATCH. This sounds to me a little bit like the sickness funds that they are using in Germany, that they become very competitive. But, nevertheless, they meet certain standards, they say what those standards are, and they deliver on that basis. It is interesting to me.

Could you tell us the President's legislative timetable on his health care plan? I think that might be helpful to all of us.

Deputy Secretary MOLEY. Senator, certainly. I would be pleased to. The fact is, 2 days ago, Treasury Secretary Brady submitted the first element of the President's plan, extension of the 100-percent tax deduction for the self-employed fully phased in starting in tax year 1996.

Today, we hope to transmit another component of the President's package, the legislative language on small market reforms and Health Insurance Networks which is similar to what you have

worked on here already in this committee, Senator Bentsen and Senator Chafee.

Next week we hope to transmit legislative language on medical malpractice, on administrative reforms, and on consumer information. We believe that the dysfunctional market could stand an increased dose of consumer information.

We believe we now have the knowledge to disseminate information in such a way as to provide consumers and purchasers with the ability to make better-informed choices on the basis of quality and cost.

Senator HATCH. Now, your testimony outlines several ways that you would hold down costs if the President's plan were enacted. Now, what do you advise that we do in the interim to hold down costs, particularly in Medicaid and Medicare?

Deputy Secretary MOLEY. We have had proposals before the Congress, as you know, virtually every year to reduce the rate of increase in Medicare. We have not been particularly successful. I think, therefore, it now calls for the kinds of actions that we are proposing in the President's plan.

However, having said that, although each of the elements of the President's plan that I indicated would be transmitted in legislative language are interactive, they could be passed in and of themselves and have a beneficial effect on behalf of the costs of health care in this country. And if they cannot be acted on in total, we urge that they be acted on individually and be viewed as such. We do, however, note that they have strong interactive effects which contain costs.

Senator HATCH. One last question. How do we put incentives in the system to increase cost-reducing technology and limit cost-increasing technology with little or no additional medical value?

Deputy Secretary MOLEY. I think that goes to the heart of cost containment, Senator. The fact of the matter is, when a person takes a drug in this country, he or she can be sure that it has gone through clinical trials.

However, as much as we all in this room, may know about health care costs and health care policy, virtually all of us purchase products from orange juice to automobiles on the basis of more information on cost, quality, and outcomes than we do with surgical procedures.

And we believe that the software and hardware are available to make that information available to consumers and purchasers so we can make better choices, more informed market-based choices in our purchase of technology and health care in general.

Senator HATCH. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman. You mentioned both primary and preventive care, which I think is critical, and also the need for more consumer information.

I am going to give you a little consumer information right now that relates to your point. I want to show you an article that ran in the Detroit News newspaper about a working mother, a single parent named Cynthia Fife, and her 6-year-old son, Anthony, and the problems she is facing.

Now, I want to understand how your program would solve this problem, so let me just take you through it. This woman works now. She earns about $12,000 a year. She has very limited health insurance coverage for herself, but none for her son through the work place. And her health coverage has not been adequate to cover her health bills, which is part of this story.

But the other part of the story is, if you can see the picture of her son right here, 6 years old when this picture was taken, he has no health insurance. Not a penny of health insurance.

For her to insure him, she would have to buy a supplemental package in Michigan that would cost here, it says in the article, about $200 a month. Now, that would be $2,400 a year, and she cannot afford to do that.

They live in a house trailer and it goes on to say what her costs are otherwise. She cannot afford to buy that package coverage for him, and he is one of the 300,000 children in Michigan today without any health insurance.

Now, I have tried to apply the philosophy in what is called the Bush Health Plan, or parts of it, the bits and pieces, to this problem. It is not here in legislative language yet. But, in terms of this, as I understand it—now, you tell me if I am wrong—that there is a proposal here to have a tax credit.

And the way the tax credit would work for somebody like Cynthia Fyfe, if she buys this policy for Anthony, if she had the money, could squeeze it out of her budget, and spend the $2,400 a year to cover him, under the Bush tax credit plan, she could put that on her tax return and she would get tax relief in the amount of about $250. Is that essentially correct?

Deputy Secretary MOLEY. No, Senator, it is not.

Senator RIEGLE. Well, then, you tell me how it would work.

Deputy Secretary MOLEY. The fact of the matter is, all people at or below 150 percent of poverty would receive a voucher.

For a family with an income of up to 100 percent of poverty, it would be worth $3,750. The amount of that voucher, that credit, would phase down at 150 percent, or be replaced by a tax deduction of which you just spoke, which would be for people of that income level and higher.

They would then submit their tax return and receive financial help in the purchase of health insurance.

For the people in circumstances like those of the individuals you mentioned, there would be a direct credit for the purchase of insurance provided by two or more insurers authorized by the State insurance commissioner to provide those policies which would pool all of those people at or below poverty. Secondly——

Senator RIEGLE. Well, let me just stop you here, because we are not communicating with one another. My understanding is, her income would put her above the 150 percent of poverty now in Michigan, so she would have to go the tax credit route.

And, in order to do that, in order to get insurance in place for him, she has got to go to a provider of insurance, she has got to pay the monthly premium, the $2,400 a year.

And my question to you is, let us say she does that. How does the Bush plan reimburse her for any or all of that $2,400? Now, she is above 150 percent of poverty. How does your plan help her?

Deputy Secretary MOLEY. If your income figure is correct, I do not believe she would be covered, Senator. But, given the fact that you are suggesting she is, she would submit that and she would get a tax deduction.

Senator RIEGLE. Now, submit it to whom?

Deputy Secretary MOLEY. On her tax return.

Senator RIEGLE. On her tax return. All right.

Deputy Secretary MOLEY. And she would receive a tax deduction——

Senator RIEGLE. Of how much?

Deputy SECRETARY MOLEY [continuing]. Of $3,750.

Senator RIEGLE. A tax deduction of $3,750?

Deputy Secretary MOLEY. That is correct.

Senator RIEGLE. Even though she has only paid $2,400 for the insurance policy for her son?

Deputy Secretary MOLEY. She receives a tax deduction for the purchase of that insurance for her and her family. You are talking about the $200 supplemental and whatever else she is paying out-of-pocket for those health care costs would form the basis of the deduction which she could submit up to $3,750.

Senator RIEGLE. All right. And then we apply her tax rate to that, do we not?

Deputy Secretary MOLEY. That is correct.

Senator RIEGLE. All right. So, what is that likely to look like? Now, you have used that figure. If I use her $2,400 of what she would have to pay out-of-pocket to insure Tony, I think she would get about a 15 percent effective rate.

Deputy Secretary MOLEY. That is correct.

Senator RIEGLE. Now, so she would get a deduction from her taxes of 15 percent of the $2,400, would she not?

Deputy Secretary MOLEY. That is correct.

Senator RIEGLE. All right. Now, let us just stop right there. So, as I understand it then, you see, when you use the words "tax credit," people do not understand what tax credit means. They think somehow you are going to get an offset for what you have spent.

In fact, what happens here, if we go down this track, she spends the $2,400, which, of course, she does not have, but, if, in theory, she stopped spending on everything else and bought this coverage for her son, she gets back 15 percent of that, under your plan. Now, that is not workable for her, is it? Or people in her situation.

Deputy Secretary MOLEY. It may not be, Senator.

Senator RIEGLE. Well, thank you for being at least that honest. Of course it is not. It is not workable for her. She does not have the $2,400 to start with, and if you give her back 15 percent at the other end, that does not do the job. You have not addressed this problem. And I think you have an obligation to do so with a plan that is real.

Deputy Secretary MOLEY. Senator, there is a second portion of the President's plan with respect to the tax credit and tax deductions that would allow States—whether Michigan, or other States such as Oregon which is already proceeding along this line—to set up their own health care systems using Federal revenues in respect to Medicaid, their own State revenues for Medicaid, the voucher or tax credit——

Senator RIEGLE. This young fellow does not qualify for Medicaid.

Deputy Secretary MOLEY [continuing]. Or tax credit monies, to set up a statewide system of health care. We expect that many States, which are already moving in this direction, will adopt that second option available to them under the President's plan in order to address the very issue that you have raised.

However, if they choose not to, you are correct. They would have additional financial help in those instances where they are able to afford it. And, for those people at or below poverty, there would be the tax credit or vouchers.

Senator RIEGLE. Well, let me just tell you, frankly, what you have just laid out is a shell game. That does not come close to meeting this problem. It is a side-step around the problem.

Deputy Secretary MOLEY. Senator, I think we will have to leave that for the States to decide. If they want to choose——

Senator RIEGLE. The States cannot solve this problem by themselves.

Senator CHAFEE. How long is this going to go on?

The CHAIRMAN. Gentlemen, let us limit this. We have several who want to ask questions. Senator Grassley.

Senator GRASSLEY. I was going to start out with asking questions that have already been discussed just now by Senator Riegle and by Senator Bentsen, so I will move on to something else that is a little more difficult to get a handle on.

And I suppose I should really be asking Deborah Steelman these questions because she is going to be addressing them, but I have got a conflict and will not be here.

These are the factors external to our health care financing and delivery system. They deal with lifestyle of Americans. They are not easy to get a handle on, but they deal with things like substance abuse, alcohol, tobacco, drugs, violent behavior, I guess you would say, risky sexual behavior; a lot of things we probably do not even want to be looking at when we discuss these things. But they are things that I think we all recognize as very, very expensive. One study suggests that these things might be costing more than $135 billion annually.

So, my question is, do we not have to address these things if we really want to get health care cost increases under control? In other words, could we not undertake major reform of our health care system and still find ourselves complaining that our health care spending is still too great compared to maybe other countries?

Deputy Secretary MOLEY. Senator Grassley, the fact of the matter is, no plan—the President's, a Canadian-style system, or any health care reform plan proposed to date—will be effective unless it is accompanied by major behavioral change in our population this decade.

The $135 billion figure you just used was the 1985 cost for cardiovascular disease alone. Certainly some of that is a result of genetic circumstances, but much of it can be avoided by very simple measures reflecting smoking cessation, reduced consumption of alcohol, more exercise, diet and nutrition.

These are all things, quite frankly, of which Secretary Sullivan has spoken at length. He has been criticized at times for not having a health care reform plan associated with them.

We have a health care reform plan now, and I think it is even more important to stress these behaviorally related issues and costs in our health care system.

The top 10 causes of mortality in our country are behaviorally related. And, certainly, we are all going to die eventually, but we can enhance the quality of life and reduce the costs associated with those diseases substantially by that major behavioral change I spoke of.

Senator GRASSLEY. We like to compare our health care system, we like to compare proposed reforms with other countries, Canada, Britain, Germany, France, et cetera.

Along that line, do we have any comparative studies or any research about the importance of these expensive behaviors in the other countries that we are comparing health care reform with?

Deputy Secretary MOLEY. Senator, in fact, part of the difference, associated with the lower cost in Canada is directly related to their lower incidences of substance abuse and violence in their society. Clearly, that has an effect on health care costs, tremendous effect.

And we know, in fact, that studies indicate that part of the differential between costs in Canada and costs here is related to those very issues. I will be more than glad to provide you the studies on which that information is based.

Senator GRASSLEY. So, you do feel that we do have enough to get a handle on, the health care reforms and the others, as we associated less cost in those systems so that if we are going to have effective reform, that we get our costs down, it would have to contain these sorts of lifestyle personal reform.

Deputy Secretary MOLEY. Absolutely. And, yet, these reforms are very simple in effect—in regard to exercise, nutrition, excessive consumption of alcohol, smoking, and things as simple as safety belts and helmets for bicyclers and motorcyclists. Those are things of which we need to be far more conscious in our society than we have been here to date.

Senator GRASSLEY. Mr. Chairman, I yield the floor.

The CHAIRMAN. Thank you, Senator. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Mr. Secretary, I was curious about a statement you made on page 3, and it is not something that is surprising, necessarily, but I think it raises an interesting question.

On page 3 you say, "Any alternative that is premised on substantial government control of choice, price, or other aspect of health care through a centralized regulatory system will never control costs effectively, nor be compatible with American values."

Do I take from your statement that the Veterans Administration and the Armed Forces Health Care systems are examples of two systems that do not control costs effectively, or are incompatible with American values?

Deputy Secretary MOLEY. Senator, as a veteran, I happen to believe there are significant cost savings that could be achieved in the Veterans Administration system if they were to use more private elements. But the fact of the matter is, that is a decision that will be made politically, not by me, but by others.

Senator DASCHLE. That is not what I am asking.

Deputy Secretary MOLEY. I think there are more efficiencies that are available in all of our systems, most particularly those that are government-regulated. I do not think a lot of people are very happy with Medicare rates, for instance, in your State or other areas of the country.

Senator DASCHLE. I did not mention Medicare. I was asking whether you think that the Veterans Administration and the Armed Forces Health Care systems are two systems that do not control costs effectively or are incompatible with American values.

Deputy Secretary MOLEY. I am not going to speak to being compatible with American values, but I think if you speak to Assistant Secretary Mendez or Secretary Derwinski, they would both voice concerns to you about the cost effectiveness of those programs. In fact, CHAMPUS is undergoing major reforms.

Senator DASCHLE. So, your answer is——

Deputy Secretary MOLEY. And they function within the context of the private/public partnership. So, I think we are very interested in expanding the private/public partnership. Clearly, there is a role for public programs in our system.

Senator DASCHLE. Do you then favor the privatization of the Veterans Administration?

Deputy Secretary MOLEY. No, I do not, Senator. I think expansion of the private/public partnership——

Senator DASCHLE. Well, a more effective way to control costs——

Deputy Secretary MOLEY [continuing]. In respect to all of our systems would be in order. But I am not calling for the privatization of the Veterans Administration's health care facilities.

Senator DASCHLE. I am just curious, because you make a fairly bold statement here that any health care system that has a centralized regulatory system will never control costs effectively or be compatible with American values.

Here are two examples, it seems to me, that fit that definition of a centralized regulatory system. And it would seem to me they are probably as integrally related to American values and effective cost control as we have in this country. But you may differ.

Deputy Secretary MOLEY. I do differ, Senator. The fact of the matter is, veterans, such as myself, are not required to go to veteran's facilities. I have never been to a veteran's facility except when I was wounded and sent back from Viet Nam.

And I am hopeful I will not. But the fact is, we have choices in CHAMPUS and in the Veteran's system. Those are not the kind of centralized systems to which I was referring to. I was clearly referring to——

Senator DASCHLE. I do not want to belabor the issue, but I think the point is clear. There are systems that are centrally controlled and really have been effectively regulated so as to control costs. I would say, and I would argue, that Medicare fits that description as well, if you look at administrative costs.

Yesterday, we were told by several of the witnesses that Medicare administrative cost is 3 percent, private health insurance administrative cost is about 15 percent. So, the administrative costs of the two are very striking, in contrast.

Deputy Secretary MOLEY. That is a somewhat deceptive figure. The statistics themselves are correct, but they are not in context.

The fact of the matter is, by virtue of the age of the Medicare population, their per capita costs for administrative matters are not nearly as low compared to the private sector as one might first assume.

The fact is, Medicare recipients, by virtue of the tremendous volume of services they require, by virtue of their age and health status, do not have comparable the administrative costs to those associated with the under age 65 marketplace.

So, although you are correct by virtue of the economies of sale, the percentage is lower; it is somewhat deceptive to simply assume that the ratio of 5 to 1 is correct. That is not, in fact, the case.

Senator DASCHLE. Well, I am sure we will get into that a lot more in the future. Just in what limited time I have remaining, do you consider tax credits and deductions actual cost containment devices? Or would you acknowledge, as I do, as a supporter of the 100 percent deductibility of health care costs for the self-employed, that it is a real recognition of cost-shifting; that we are shifting what is normally a cost to insurance payers, really as a cost to be borne by the taxpayer. Is that correct?

Deputy Secretary MOLEY. Senator, I agree with a good part of what you said. In fact, there is tremendous cost-shifting going on, both in our public systems, Medicare and Medicaid, as well as in private insurance where 28 cents on the dollar is, in fact, cost-shifted from other uncompensated care.

But I also believe that the tax credit and the tax deduction will put in the hands of consumers an opportunity to purchase insurance, which, combined with consumer information and administrative efficiencies, will, in fact, help cost containment efforts. I think that is an integral part of what we are dealing with here.

Senator DASCHLE. I am out of time. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Mr. Secretary, I did not intend to ask a question, but, because of the questions asked by the Chairman and by my colleague, Senator Grassley, I want to pose a question and not necessarily provoke a response.

But the Chairman asked you about universal coverage. And I do not know that I have seen the universality in the President's proposals, and I do not think it is posited as a total answer to the coverage question.

And all I can do is reinforce the fact that when the Chairman of this committee asked that question, it means that people on both sides here are looking to an answer to the question; where is the President on the issue of universal coverage, at least for medical expenses, if not long-term care?

But the question that Senator Grassley asked is related to that. One of the good things about Canada, if you ever take the time just to simply open up the brochure that they will give you when you go to Canada that talks about their national system, that Canada has an articulated national policy commitment that helps the people define what health is. We do not. There is no place in this government you can find that.

So, we sit here and we debate the presumption that we are arguing over the kinds of things that are covered in health insurance plans.

But Senator Grassley says, why is it that we have just decided to spend $600 million not to remedy a jury verdict in Los Angeles, but a drop in the bucket for a very serious health problem that this Nation faces and none of us is doing anything about? He is raising the issue of the health and well-being of the people of this country. I cannot even get an answer to this.

Your department supervises literally hundreds of programs created in the 1960's that, by implication at least, some people, at least on this side of the table, perhaps, or the President most recently, have been somewhat critical of in terms of their effectiveness in dealing with some of these problems.

But it troubles me no end to sit here and debate only the $821 billion that is committed to the medical remedy system when I cannot even tell how much of those medical problems are being created because we fail as a society. And I am not just talking about the national government. We fail as a society to deal with the issue of health.

Now, the Canadians say health is first. Health, well-being, mental, physical, spiritual, however you want to describe it. That is a Canadian commitment.

And then they say it includes environmental health: clean air, water, and it includes the usual public health standards. It includes, like we have just been debating, taking lead out of gasoline, and issues like that. And it also includes occupational health. And all of these are related to the health of people.

So, I said in the preface to this, I do not intend to provoke a response, necessarily today, but I think what elections are all about, as well as hearings like this, is for the national leaders of this country to speak to these cost containment health care problems the way people see them.

People do not just see them as a cost of insurance problem, they see them in this much larger context. And I think it would be helpful to everybody here if the administration, the President, and each of us begin to articulate it in that larger context as well.

Deputy Secretary MOLEY. Senator, I agree.

Senator DURENBERGER. Thank you, Mr. Chairman.

The CHAIRMAN. All right. Thank you very much. Senator Danforth.

Senator DANFORTH. I want to make one request, offer one comment, and then ask you a question.

My request is that the administration take a careful look at the legislation that Senator Kassebaum has introduced. I think that it is very significant and deserving of attention, and I would like you take a good look at it, hopefully with an open mind.

My comment is based on the same sentence from your statement that Senator Daschle read, and I want to re-read it. You say in your statement, "Any alternative that is premised on substantial government control of choice, price, or other aspects of the health care system through a centralized regulatory system will never control costs effectively, nor be compatible with American values." My comment is, I doubt that. I doubt that.

I believe that some method of hard control is going to be essential if we are going to control costs, and I do not believe that it is necessarily incompatible with American values.

My hypothetical question to you is as follows. Let us say that some genius at a medical school develops a new procedure, new equipment, some kind of gizmo, and that what this equipment will do is to extend people's lives by 3 months, people who are otherwise going to die, at a cost of, let us say, $1 million per person.

Is there anything in the suggestions of the administration that would put any damper on the offering of that kind of a program?

Deputy Secretary MOLEY. I think, Senator, that the choice you put forward is best determined from the bottom up and not from the top down, which goes to the very heart of this issue about a centralized or decentralized system.

I think a decision as to whether to make that technology available—how it is made available, at what cost, and to whom—is better made locally. It is better made by the people of your State or others, better made by those who are offering the programs and plans from which people can make choices as to what kind of risk they want to take. I just am very concerned about the Federal Government making those decisions across the board for all Americans.

Senator DANFORTH. All right. Now, is it, therefore, your view that if such a new procedure is developed at the cost of half a million dollars, keeps people alive for 3 months and people decide they would like it; they are just as happy as clams, you put them in some isolation booth for 3 months and they are happy, and they want it, and their families want it, is it your view, then, that the Federal Government should simply pay for it?

In other words, the role of the rest of the country is to ask us what they want. And our role, as good politicians, is to say, why, of course, you can have it, we will pay for it.

Deputy Secretary MOLEY. Well, as I said, Senator, I think that goes to the heart of my concern about decisionmaking in a top down fashion. I really believe those decisions are best made locally and to the degree possible——

Senator DANFORTH. Do you mean to say that people at the local level, therefore, should tell us what they want and then we should say, all right, you have told us what you want, we will pay for it?

Deputy Secretary MOLEY. As an example, Oregon has a waiver requirement request before us which suggests that there are some 586 out of 709 procedures for which they should make payments.

They have gone to large trouble to develop consensus in respect to that. We are not necessarily in agreement about the specifics of that and we will deal with that situation very shortly.

Senator DANFORTH. That is fine. But——

Deputy Secretary MOLEY. But I would suggest those kinds of——

Senator DANFORTH. All right. But nobody is going to make that decision unless there is some limitation on the budget. Is that not correct? I mean, unless there is some cap on what is being spent, somebody saying no to how much is being spent, then everybody is going to say yes to every particular procedure.

Deputy Secretary MOLEY. Absolutely. And that is a cost of the kinds of systems that are top down. In a response, I believe, to Chairman Bentsen yesterday, Dr. Reischauer indicated that we

would have cost caps, expenditure caps at the price of increases in the pace of technology and the expensive choices.

I think that is a very telling comment. And I do not think the American people are ready to be told that the Federal Government in Washington is going to suggest that the people should have such procedures.

Senator DANFORTH. So, then, you are saying that the Federal Government is not in a position now of saying no to anything. In other words, if the people want it, we give it to them.

Deputy Secretary MOLEY. I do not think we have had a lot of good experience that indicates it can.

Senator DANFORTH. Well, certainly not.

Deputy Secretary MOLEY. I mean, there are two kinds of cost containment. If you cap expenditures at some total, all you will do is run up against the kind of pressures of which you are giving an example. And I think when that time comes we will just expand the expenditure caps.

I would like to think that markets which work in virtually every other segment of our society, based on consumer information, are better able to make those decisions and most likely are able to make them at the lowest possible level. I would suggest they could be best made at the State level.

The CHAIRMAN. Thank you very much. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. And thanks to the Secretary for being with us. As you can see, there are probably as many approaches as we have members of the Congress on what to do, and it is about the time when we are going to have to jump one way or the other. We are fast approaching that time with the schedule we have.

I am interested in the fact that the recurring theme, I think, throughout your testimony is talking about a market-based system that promotes consumer choice, encourages individually-based decisionmaking as part of the ultimate solution.

Let me ask you, first, just a short question. I have seen information that says that two-thirds of all of the medical care spending per individual in this country is really less than $3,000 per person, per year. Is that pretty much a ball park figure? Is that correct?

Deputy Secretary MOLEY. That is correct. That is basically correct.

Senator BREAUX. Let me ask you, then, your thoughts on an idea that we have just about finished the final drafting on, which would establish a medical care savings account.

If you take a typical plan that an employer has with his employees for their family, and that employee, say he is spending $4,500 a year on that plan as a contribution.

Say we have a plan that allows him to contribute $3,000 to the employee to establish a medical savings account for that employee and make it deductible to the employer to encourage him to do it.

But that account belongs to that employee. He can take it to another job. If he loses his job, he still has it. He uses it to pay his medical expenses up front.

It eliminates the paperwork, he does not have to file claim forms, the doctors and hospitals do not have to file them either. He uses it to pay his doctor bills. If he does not use it all, he retains it, he

keeps it. It goes to the next year, the employer makes the same contribution. It builds up in his account.

Ultimately, he could take it and use it for other purposes if he paid a penalty and also paid income tax on it, but it is essentially a medical savings account.

That employer would use the other $1,500 remaining of his typical contribution in order to buy a catastrophic policy for that employee that covers all costs over and above the $3,000.

Now, this does not address the people who do not have insurance. It is not an all-encompassing plan; it is not intended to be.

The question I want to ask you is to comment on it in general, but, also, specifically with the question of does this encourage a little bit of discipline with the individual whom I think right now, because a third person pays for it, is less likely to be disciplined and careful in how they seek their medical treatment in this country, as long as Uncle Sam pays for it, or as long as an insurance company pays for it. Could I just have your general thoughts on this?

Deputy Secretary MOLEY. Senator, it is a very interesting idea, one which we are reviewing with a great deal of interest. Yesterday afternoon, I asked Dr. Paul Elwood, one of the principal proponents of the managed competition idea about which Professor Enthoven testified yesterday, to meet with J. Patrick Rooney. Mr. Rooney is one of the principal proponents of this idea, and we want to hear his views on whether or not this was compatible with the managed competition idea that Professor Enthoven is espousing, as well as whether it is compatible with increasing the use of managed and coordinated care.

It has a very interesting feature, to which you alluded, altogether too often we are shielding people from the true nature of the costs of their health care, and, at the same time, adding administrative expenses. This blizzard of paperwork could be substantially reduced using the medical savings account idea.

The administration has not taken a position on this yet, but we are viewing the idea with a great deal of interest.

Senator BREAUX. I know it is not perfect and there are some pitfalls to it, and there are some things that need to be carefully answered before anybody should just accept it.

But I am intrigued by the idea of the elimination of the paperwork. Insurance companies that I have met with on this tell me they spend as much money processing a $50 claim as they do to process a $5,000 claim. This would eliminate that. The patient pays out of his of her account and there is no paperwork back and forth to third parties.

I think the other thing that is intriguing is if a person loses his job, that this account is theirs. They can take it, use it until they get their next job, and they are protected. We do not have that situation currently.

And I would like to think that it would encourage people to be a little more concerned about what their health care is costing so they can make better choices.

People say, we do not know whether they are going to make the right choice. Well, I suggest let try it. We have never given them that authority. I think it is something we should pursue. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. No questions.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Just a couple of comments, and then one question, Mr. Moley. I believe your department is correct, in its stressing the importance of lifestyle: not smoking, seat belts, motorcyclists helmets, and the dangerous proliferation of guns.

I was interested to see the statistics that both in Louisiana and in Texas in 1990, more people were killed by guns, handguns and rifles, than by motor vehicle accidents, which is a stunning statistic.

Secondly, we have had some discussion here of Medicare and the implication that that is the way to go, that that holds down costs. It is my understanding that despite the DRG's and the RBRVS that the costs in Medicare are going up about 12.5 percent per year. Is that right?

Deputy Secretary MOLEY. That is correct, Senator.

Senator CHAFEE. And that is not all due to increased case load, I presume.

Deputy Secretary MOLEY. No, indeed, it is not. It is in large measure involved with increased utilization, technology, and demographics.

Senator CHAFEE. So, that just does not seem to be the total solution, either. Also, we had some discussion yesterday of the Canadian system. And, as I see the Canadian system, initially there would be substantial savings in administrative costs.

But once those savings have been registered, then, as I view the Canadian system, the costs go up per capita as great, and, indeed. greater than the U.S. health care costs. So, in the Canadian system they do not seem to have gotten control of costs, either.

Now, Dr. Enthoven set forth a rather interesting proposition yesterday here. He was talking about a system of group purchasing organizations.

And he believes that in order to achieve true competition there has got to be a uniform benefit package that is offered, that each of the insurers must offer exactly the same package.

And then the sole criteria of the selection is made by the beneficiary based on cost and quality. By not permitting differentiation of packages, he thus would prohibit the young, healthy people all going one direction and leaving the older or less health individuals for the others to pick up.

Now, in developing your HIN's, have you considered that proposition? Could you comment on that briefly?

Deputy Secretary MOLEY. Yes, in fact, we have, Senator. And, quite frankly, at this stage we are not prepared to sacrifice the level of choice in plans to a standard benefit package.

However, I would like to be very careful in saying that, because I think many of the ideas Professor Enthoven has come forward with in this arena are of tremendous interest to us. And we do not believe that our idea of HIN's is that far removed from his idea of HIPC's.

However, at this stage, in development of our proposal, which will be coming to the Hill today, we recognize that there are a

number of organizations already in existence that would like the option to band together and provide different kinds of plans for their employers.

COSE, in Cleveland, has, I believe, a dozen different plans which it offers to its members. There are things that we very much like about that. There are other things in respect to medical underwriting, of course, that we would prohibit under the proposal that we will be sending up, very much like your task force plan, and Senator Bentsen and Senator Durenberger's proposals.

Senator CHAFEE. It just seems to me that we all laud choice in the American system. And, indeed, in this statement that there has been some discussion on, governmental control of choice is not compatible with American values.

But, I truly believe that if we are going to get control of these costs we are not going to be able to have the freedom of choice. After all, that is a fee-for-service situation, is it not?

You can go to any hospital you want. You can go to the hospital of your choice. You can go to a hospital that rarely does open-heart surgery, even though, as I understand it, the American College of Surgeons says that any hospital that does less than 150 a year is not getting the expertise that it should have. But you can go to one that does three a year under your proposal. Is that right?

Deputy Secretary MOLEY. Senator, I think there is an understandable misconception about the word "choice." What we are talking about is a series of choices.

A threshold choice may be whether one wants to participate in a fee-for-service situation. Another choice, 180 degrees in the opposite direction, may be participation in a closed-ended staff or group model HMO. Increasingly, however, as the market evolves, more choices are becoming available—choices of different kinds of plans.

We are very interested in the point-of-service kinds of plans whereby, patients go to the preferred provider listed by the insurer; there would be little or no deductible and co-pay.

If a patient wants to maintain full choice and go outside to any provider of choice, there would be a significantly higher co-pay and deductible, albeit with maintenance of some level of insurance. Those kinds of newly-evolving circumstances, we believe, are very important.

The CHAIRMAN. Thank you, gentlemen.

Senator CHAFEE. Thank you. This is a fascinating area. Thank you.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Yes. Thank you, Mr. Chairman. I am fascinated, going back to page 3, Mr. Moley, by your hanging onto a concept that we may follow. Specifically, the administration seems to think that keeping with the market-based system is our salvation in reforming our health care system.

The market-based system is the very same system that has produced the highest per capita payment for medical expenses in the world and the highest cost of prescription drugs in the world. Under this system, it is manufacturers, the doctors, the providers, the nursing homes who control both the supply and the demand.

And the consumer, basically, is left out of this equation. They have very little to say about it. How can we take the market-based

system and hold this out as the hope for not only access, but health care that we can afford?

Deputy Secretary MOLEY. Senator, I, in fact, do not disagree. And I am sure we could go on at great length, but let me try to be very brief, knowing that time is short here.

We agree there is a dysfunctional market. In fact, we currently have virtually no market currently for individuals. We lack choice. We lack choice because we do not have the information available to us.

Yet, we know statistically that the knowledge has become available in recent years to indicate there are hospitals within 40 miles of one another where the same operation costs $26,000 at one location and $17,000 in the other.

And, as anyone who has any degree of familiarity with Economics 101 might expect, the lower cost hospital, by virtue of the economies of scale related to doing 150 or more operations per year, is generally going to give us better outcomes.

We have lacked information with respect to outcomes, cost, and quality in the health care system. We have more information when we buy orange juice to automobiles in our society than we do when we have a surgical procedure.

We are fundamentally insisting that in the reforms that the President is outlining that we bring that information to the public's attention to give them the opportunity to make those kinds of choices.

Senator PRYOR. Now, my colleagues get amused at me because I have become sort of stuck on one issue in the last several months. [Laughter.]

But you said that you lack information. Let me give you some information. [Laughter.]

Here is some information right there. And I used this yesterday. We are seeing that the drug companies are, once again, increasing drug prices three times at the rate of inflation. What is this administration doing about that?

Deputy Secretary MOLEY. Currently the consumer is at the mercy of the prices that are charged, clearly. And that is because they do not, or very seldom have the opportunity to band together.

But Kaiser, Humana, and other private, not-for-profits, purchase drugs, generally, as they do other services, on a far more efficient basis.

When you have some segments of the economy that do not know what costs are going to be and do not have protection from those costs, the costs are going to balloon; consumers are going to be charged the excess when you cut down on only one area of the equation.

What we are looking for is to broaden the base of consumers, purchasers who make informed choices about the cost of not just pharmaceuticals, which is important enough, but also of surgical procedures, hospital and doctor costs of all kinds. We are absolutely in agreement that we need to empower consumers and purchasers to make more informed choices. Absolute agreement.

Senator PRYOR. Well, this is an incredible answer, I think, to a problem that we know exists. I think we are living in a make-be-

lieve land, Mr. Moley, if we would accept your prescription for solving our problem.

Deputy Secretary MOLEY. Senator, with all due respect, it works in every other element of our economy.

Senator PRYOR. This is not like any other element of our economy, Mr. Moley.

Deputy Secretary MOLEY. It is not——

Senator PRYOR. Because the consumer has absolutely no control of these costs and on what services and products we really need.

Deputy Secretary MOLEY. That is absolutely correct.

Senator PRYOR. The providers, the manufacturers, the doctors control demand as well as supply.

Deputy Secretary MOLEY. That is absolutely correct, Senator.

Senator PRYOR. They make that decision for us.

Deputy Secretary MOLEY. And we have two choices. We can leave them in the dark, or we can turn on the lights. The President's plan suggests turning on the lights, providing consumer information, giving every opportunity across the spectrum of the health care economy, an opportunity for consumers to make more informed choices. And I think that is in all of our interests.

Senator PRYOR. Well, can I tell you about an informed choice that 5 million Americans today are having to choose whether they buy prescription drugs or food? What kind of a choice is that?

Deputy Secretary MOLEY. A bad choice. And we need to reform it, and we intend to do it.

Senator PRYOR. This administration has done nothing to reform it. Nothing. And I wish you would point to me one thing you have done.

Deputy Secretary MOLEY. Senator, I recommend to you the 94-page plan of the President. We would like to see it enacted as quickly as possible.

We believe it will provide the consumer choice that will help control costs, that will, as I said earlier, enable us to make more informed decisions about the purchase of not just pharmaceuticals, which, as I said, is important enough. But in health care we do not make the kind of choices that we make in the everyday purchase of goods and services.

Senator PRYOR. Mr. Moley, my time has expired. Thank you.

The CHAIRMAN. I would say, Mr. Secretary, that I am sure that the members of this committee would like to have you here all morning to ask you questions that are of deep concern to them. [Laughter.]

But I ask a commitment from you that they be able to submit questions to you in writing and that you give us an answer to them.

Deputy Secretary MOLEY. And we will do so promptly, Senator.

Senator RIEGLE. Mr. Chairman, I know you are very pressed for time.

The CHAIRMAN. I really am, Senator. [Laughter.]

I have got a long list of witnesses here. You are asking for one more question?

Senator RIEGLE. Well, I want to, if I may—and I am sensitive to that because I know what it is like to have to run a committee in a situation like this—pursue briefly the first issue that I raised

that I was not able to finish because the time expired, but that I think is important.

The CHAIRMAN. All right, Senator.

Senator RIEGLE. And, if you will indulge me, I will not ask for that again anytime soon. [Laughter.]

The CHAIRMAN. All right, Senator. Go ahead.

Senator RIEGLE. I want to make reference to an analysis that has been done by the Children's Defense Fund. I know you are familiar with that organization. It is a highly respected national organization; many people belong to it, Democrats, Republicans, Independents, and so forth.

They have analyzed the plan and how it would work—what there is of a plan, the bits and pieces of what the administration is suggesting—on how it would affect low-income children in the company, like Anthony Fyfe, that I talked about here.

Their view is that the plan—and they call it that, they say, "President Bush's Health Care Reform plan is a hoax. It offers very limited health to millions of middle-income and poor uninsured children, while it takes away from poor children in Medicaid."

We did not get to that before as to how its proposed to provide even this meager tax credit, which sounds like a lot of dollars. But then, when you factor it by the tax rate, it turns out to be very little.

They point out here that a single parent with just one child, earning about $13,000 a year, would receive only $250 from the tax credit.

Now, I cited the cost per month of Cynthia Fyfe insuring her son. This is in 1991. The figure today, because of the rise in these health care costs, is higher than that. So, the cost would be at least $3,000 a year for her to insure him, from which she gets about $250 back, given her income bracket.

They go on to point out, to pay for the tax credit, as meager as it is and as insufficient in terms of providing care, that not a single child, in fact, would get an insurance card or would be provided direct access to a doctor or a clinic under that particular plan.

But they point out how the cuts in the Medicaid program are designed to cover the tax credit, so that goes to the poorest children in the society.

I will not take the time to read it all here, but it says that "the President proposes to reduce the benefits for children and pregnant women in Medicaid," and it goes on to lay that out here in detail.

There is no other country in the world, by the way, that does this; that both uninsures its children, and, then, in effect, takes from the poorest children in the country to try to provide a tiny, tiny benefit for the people the next rung or two up on the ladder. And I ask that the full statement of the Children's Defense Fund be made a part of the record. These are serious people.

The CHAIRMAN. That will be done.

[The prepared statement of the Children's Defense Fund appears in the appendix.]

Senator RIEGLE. They are every bit as serious as you are. And they say this plan is a hoax, and I have to agree with them. I think it is a hoax.

Deputy Secretary MOLEY. Senator, if you have accurately reflected their comments in respect to Medicaid cuts reducing benefits for children, you are absolutely right, it is a hoax. Their report is a hoax, if you are accurately representing it in respect to our cutting Medicaid. We have no intention of cutting Medicaid.

Senator RIEGLE. You do not cap Medicaid expenditures? We have to pay for it. You do not cap it?

Deputy Secretary MOLEY. We are increasing Medicaid expenditures. We are not cutting Medicaid in any way and in no sense of an accurate description of that word.

Senator RIEGLE. Well, I disagree with you. The fact of the matter is, you are proposing to pay for it by a cap on Medicaid that is below the inflation that is occurring, and you know that. And that is a dishonest and disingenuous answer.

Deputy Secretary MOLEY. I do not think that is proper if you are suggesting——

The CHAIRMAN. Senator, I am letting him make his statement and you will be allowed to make yours.

Deputy Secretary MOLEY. Senator, if you are suggesting that the 5-year projection of 17-percent increased costs per annum in Medicaid is appropriate, you have only one of two conclusions.

One, is (a) those are unsustainable and will bankrupt the system, and, two is (b) that all of those expenditures are being made in the most cost-effective way.

And I suggest to you that if you go to the Medicaid walk-up store-front mills in New York City or other urban areas, it defies logic to suggest that we are doing as well as we can in Medicaid.

And we strongly suggest and recommend the passage of S. 2077 as a small step. We expect its counterpart on the House side to be introduced by Congressman Ed Towns. We, the President and the administration, have endorsed it. It has been cosponsored in the Senate by Senators Moynihan and Durenberger, and has other substantial support.

That is the first small step we could take to help Medicaid recipients without pointing figures as to what is a cut and what is not. But we are not intending in any way, shape, or form to reduce Medicaid expenditures.

The CHAIRMAN. Senator Chafee, do you care to comment?

Senator CHAFEE. No, I do not. I think terms like dishonest are inappropriate terms. It is easy to sit up here on this dais and badger witnesses. There is a lot of power that comes with it. But I think it is inappropriate, Mr. Chairman.

The CHAIRMAN. Well, I must say I had trouble with the Secretary's answer myself.

Senator CHAFEE. Well, you did not call him dishonest.

The CHAIRMAN. Thank you, Mr. Secretary. We have other witnesses.

[Pause.]

The CHAIRMAN. Our next witness, Mr. Lane Kirkland, who is the president of the AFL–CIO. We are very pleased to have Mr. Kirkland and are looking forward to his statement.

There is no question about the intensity of the concern on this issue. I think it has been demonstrated that the members of this

committee are deeply concerned. We are looking forward to your contribution to the discussion.

STATEMENT OF LANE KIRKLAND, PRESIDENT, AFL–CIO; WASHINGTON, DC, ACCOMPANIED BY ROBERT McGLOTTEN, DIRECTOR, LEGISLATIVE DEPARTMENT, AND KAREN IGNAGNI, DIRECTOR, DEPARTMENT OF EMPLOYEE BENEFITS, AFL–CIO

Mr. KIRKLAND. Thank you, Mr. Chairman. I have submitted a longer statement for the record and would like to summarize it.

I have with me today, Bob McGlotten, the director of our legislative department, and Karen Ignagni, who directs the department of employee benefits. I will ask them, perhaps, to handle questions which I am too untutored or dumb to deal with.

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues for working people and their families.

Increasingly, union members are concerned about preserving their negotiated health benefits, the benefits they have today. This concern is warranted.

In recent years, the majority of labor-management disputes have been caused by the nation's health care needs. When these disputes could not be settled at the bargaining table, all too often the workers found themselves permanently replaced when exercising their legal right to strike.

A recent study by the AFL–CIO Employee Benefits Department found that in 1990, health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job-loss in a strike over health care.

Last fall, the AFL–CIO commissioned a study by Lewin ICF, Inc. to determine how much could be saved if Congress established a single cost containment program for all payers.

They estimated that just a 2-percent reduction in the projected rate of growth in health inflation would save $165 billion in 1990 dollars by the end of the decade.

Recently, the Prospective Payment Review Commission issued a study that supported these conclusions. PROPAC estimated that if the Medicare payment rates were extended to private payers, there would be an immediate cost savings of $16–$21 billion annually.

As part of its deliberative process, we would urge the committee to compare the costs and performance of the U.S. health care system to those of our industrial partners.

While these systems have unique structures and differ on numbers of payers, all of these countries have achieved universal access to health care benefits and effectively controlled costs by setting budget targets and paying providers uniform rates.

We urge the committee not to be distracted by the myths of rationing, excessive government bureaucracy and inferior quality that have long been advanced by those who oppose reform.

Taken together, the health care systems throughout the industrial world provide conclusive evidence that it is possible to provide coverage to all Americans far more effectively and at an affordable cost.

The burden is on those that advocate market-based mechanisms to explain why we would continue with "voluntary efforts."

In this Congress I have testified before each of the House and Senate committees that have jurisdiction over health care. The one proposal that we reject out of hand is small market reform. No amount of political spin control will convince our members that this proposal moves us forward.

In our view, the term small market reform is not synonymous with health care reform, which must encompass comprehensive reforms in the organization of the health care system, payment of providers and delivery of care.

The lessons of proposals already in place within certain States is that small group market reform will not make health insurance accessible and affordable unless it is an active part of a comprehensive package that controls costs and guarantees coverage.

The labor movement is united in its pursuit of fundamental restructuring of the system. We have three essential goals: to contain health care inflation; to provide all Americans access to care; and to improve the quality of services.

All of the unions within the AFL–CIO support these goals. Attached to this testimony is a copy of our recent convention resolution on health which describes our prescription for reform. Some of our affiliates support the implementation as soon as possible of a single payer approach.

But all of the unions believe that we need Congressional action now to address the health care crisis, and they support the federation's efforts to get legislation that conforms to our principles enacted as soon as possible.

As a nation, we cannot hope to expand access or improve quality without controlling health care costs. The AFL–CIO has proposed a comprehensive strategy to bring health care inflation under control.

To achieve this objective, we have urged Congress to establish a national commission composed of stakeholders in the system—labor consumers, management, government, and providers—to administer a single national cost containment program.

The primary functions of such a commission would be to conduct negotiations between health providers and purchasers of care on payment rates and other necessary measures to achieve these targets and to establish controls on capital costs.

Once payment rates are negotiated, they must apply to all payers, including government programs, to prevent cost-shifting. The commission should use the methodology that has been implemented successfully under Medicare.

Payments to hospitals should be on a DRG basis, with adjustments for facilities with special needs. Payments to physicians should be on the basis of a resource-based relative value schedule, with geographic adjustments, as necessary.

We believe it is time to overhaul our costly administrative structure by establishing requirements for administrative intermediaries that would standardize claim forms, develop a uniform health care information system, and simplify paperwork.

That means that Congress must establish Federal regulations for insurers and managed care providers as we seek to improve the efficiency of this system.

The task before this committee is to define the combination of public and private strategies that will make our system live up to its reputation as the best in the world. We can reform the health care system now if we commit ourselves to get on with the job.

To advocate anything less is to accept the inevitable chaos in which the nation's resources continue to be misapplied and drawn into the black hole of uncontrollable costs.

No combination of voluntary efforts will be enough to solve the deep-rooted problems of rising costs, diminishing access, and uneven quality. It is time for all members of Congress to exercise the type of leadership the American people deserve from their elected officials.

It is time for Congress to take a hard look at the effects of the health care crisis on their constituents, and time to develop and enact the comprehensive health care reforms that working men and women so desperately need. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Kirkland, thank you.

[The prepared statement of Mr. Kirkland appears in the appendix.]

The CHAIRMAN. We had a number of experts testifying yesterday. One of them, Professor Enthoven, is suggesting a managed competition as part of the solution to getting health care costs down. This is being used by the California Public Service Employees Fund on the West Coast.

We had Dr. Paul Starr, who is in favor of national health insurance with a single payer, and sees a possibility of incorporating managed competition within State-operated health insurance programs.

Now, one of the critical parts of Professor Enthoven's proposal is to limit the deductibility of employer-provided health insurance premiums by allowing individuals to deduct only the cost of the least expensive alternative plan.

I know organized labor is opposed to a limit on deductibility. But, as we try to pay for these things and figure out how to do it, do you know of any circumstances under which that might be acceptable?

For example, dealing with tradeoffs, if the benefit package was a comprehensive one—and Professor Enthoven kept emphasizing that is what they have, for example, at Stanford—or if a limit on deductibility was viewed as an alternative to increased deductibles or increased co-insurance that individuals would have to pay when they got sick. Do you see any alternatives that might be acceptable where you had a limit on the deductibility above a limit?

Mr. KIRKLAND. I do not think the issue of what particular benefits are basic and essential and what particular benefits are regarded as somehow outside of the area that are essential, basic requirements of people's access to decent health care.

And to attempt to draw those distinctions, I think, is going down the wrong path. Let me just say, on the question of financing, our members are paying now, they are paying heavily.

Every dollar that goes into these health plans that we have been able to negotiate that we are struggling to maintain with great difficulty comes out of their pockets in one way or another.

We want a system through which the vast resources that are already being committed to in the cost of health care in this country, can be organized and applied in such a way that access is universal, that costs can be effectively controlled.

We do not think the issue of the extent of deductibility effectively addresses the issue of controls on those costs. With respect to the financing of a plan, we are totally open to all possible sources of financing. But you cannot answer that question in the abstract without telling us what is the package that is funded, what is there? So, the only way I can really answer you is, show me the package.

The CHAIRMAN. Yes.

Mr. KIRKLAND. Show me the package.

The CHAIRMAN. Now, one of the alternatives he was talking about was a comprehensive package, whatever that might be.

Mr. KIRKLAND. Yes.

The CHAIRMAN. You would still want to see that, I assume.

Mr. KIRKLAND. Yes.

The CHAIRMAN. One of the things that you are suggesting on the national commission, as I understand it, the one that would oversee cost containment——

Mr. KIRKLAND. Yes.

The CHAIRMAN [continuing]. Is that all of the payers would be required to use the same fee schedules, suggesting that all the stakeholders be represented on the commission, whether you are talking about labor, or you are talking about consumers, business, government providers, and that the commission oversee negotiations for health care prices.

Now, do you see any conflict in having the participants in the negotiations represented on the commission itself? Some people are proposing a Federal Reserve model where the members of the commission were more disinterested experts. What is your view on that?

Mr. KIRKLAND. My view on that is the Federal Reserve model is not one that I would care to apply to such basic issues that have to do with the life, death, and survival of people.

I think it is vital that the people who are most directly affected and who have this stake be represented in these negotiations in this forum where these issues are addressed and resolved.

To take it out of their hands and to move it up to some unresponsive group of hypothetical disinterested people seems to me to be dead wrong. We have problems with the structure of the Federal Reserve system with respect to the issues that they address now.

We do not think it is sufficiently representative or sufficiently responsive to the people who are so drastically affected by their decisions made in an ivory tower. We do not think it should be an ivory tower operation.

The CHAIRMAN. I see my time has expired. Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman. And thank you, President Kirkland, for your testimony and the leadership the labor movement has given in this area.

Am I correct in believing that today, in collective bargaining, that preserving health care coverage is just about the number one issue in case after case across the country with companies large and small?

Mr. KIRKLAND. It is the single most difficult and most troublesome issue that we confront in collective bargaining today, and it is the issue that is most likely to lead to impasse and to provoke strikes.

Senator RIEGLE. Is it not also fair to say that no matter how hard you bargain on your side of the table, or how hard management may bargain on the other side of the table, that neither side of the table, separately or together, can solve this problem the way it sits today in our country?

Mr. KIRKLAND. That is entirely true, sir, and it is not because we have not tried. We have a group of trade union people, a group which I Chair on the labor side, that meets regularly with a group of prominent business leaders, the chief executive officers of some of our leading corporations, we call it the Labor Management Group.

And this has been a recurring issue that we have attempted to thresh out in that forum and to try to find common ground and common approaches.

Some years ago, we agreed upon a common approach. Both sides were afflicted with this problem; both sides recognized it; both sides feel it in the harshest possible way; and both sides recognized that we need to work on it together where we can.

That group developed some years ago, and we will be glad to provide the committee with a copy of those approaches that we developed.

We developed recommendations for labor and management groups as to how they might work together and jointly approach the providers of medical services and the carriers within the communities where our people are located, and attempt to work together in order to negotiate and restrain these costs. And those recommendations were widely circulated throughout the labor and management communities.

And there were efforts undertaken, approaches developed consonant with those recommendations. And I have to tell you that they did have some useful impact, but overall and in the main, they did not restrain the continuing escalation of medical care costs.

And they further convinced us that this was a problem in an area which neither labor on its own, or management on its own, or us both working together in good faith and with the best objectives in mind, could resolve. It takes a national concerted comprehensive approach.

Senator RIEGLE. The picture that I see out there in Michigan and across the country is that workers and their families, union and non-union, are being crushed by these costs; many do not even have coverage. The companies are being crushed by these costs. Neither can solve it by themselves or together, as you have just testified.

And it seems to me as long as the cost-shifting arrangements are out there where, in the workers that you represent who have some

measure of health insurance coverage, if that health insurance coverage is going to have to carry the added weight of all of the shifted cost that moves through this system from some other place, that the system inevitably has to break down, and, in fact, is breaking down. Is that not what is happening today?

Mr. KIRKLAND. There is no question about it. Our concern is for the very large numbers of American families who have no coverage and no protection whatsoever.

It is moral, and it is ethical, and it is a matter of humanitarian concern, but it is far more than that. It is a matter of direct dollars and cents concern, because those costs are borne by the plans that we have succeeded in establishing.

They are shifted to them and that element of that cost that they bear of unpaid medical care, hospital costs, doctor's costs, are very, very large and very burdensome.

Senator RIEGLE. We have developed a plan, several of us here—Senator Mitchell, Senator Rockefeller, Senator Kennedy and I—that is an approach that is comprehensive.

You may support part of it and differ with part of it. It is an effort to try to deal in a comprehensive way with the problem that you have outlined. I think we have got to have a comprehensive plan. I think to say that there is no consensus is really an excuse not to give leadership.

I mean, the job of leaders is to either form a consensus or to lead the way out of a stalemate to a better system. And I think we can do it, and we ought to try to do it this year. Thank you.

The CHAIRMAN. Thank you. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Welcome, Mr. Kirkland. I want to clarify what you have just said about your interest in and concerns about Federal cost containment boards.

Your testimony calls for a commission which would set up a national cost containment program, and I understand your reasons for making that kind of a proposal.

But I guess I would wonder, given the experience that we have seen in the country today with regard to the disparity in rates and the disparity in payments and the difficulty in trying to appreciate the differences that exist within our health care system geographically.

South Dakota's rural health care delivery system is vastly different than what we might see, for example, in Southern California or in Chicago.

Why would it not be better to take that you suggest is a Federal board and allow the States to take what would be allocated resources and make the negotiations to reach that global budget at a State rather than a Federal level?

Mr. KIRKLAND. You are proposing that the commission be established State by State rather than a single——

Senator DASCHLE. That is correct. With a national board which would determine the overall benefits package and the overall global budget, but the allocation of resources back to the State and allow them to administer it, allow them to take into account the differences.

Mr. KIRKLAND. I think the national commission should certainly incorporate within its deliberations and within its actions the fact

that variations in conditions in different parts of the country, different regions, different States, and that there can continue to be a role for State bodies and State approaches within that framework.

Senator DASCHLE. I am not sure I understand your answer. Could you elaborate a little bit?

Mr. KIRKLAND. We have said in our proposal that a national commission can take into account varying conditions in the States and use methodologies and machineries that are applied and developed at the State level. We do not think it is incompatible.

Senator DASCHLE. Well, it seems to me that we are creating the same bureaucracy and the same ineffective application of health care policy through that kind of an approach that we have had for many years through the system that we have today.

One of the real values to having a State-based system is to take into account the values and the differences that occur at a State by State level.

They do that in other countries and it would seem to me that we ought to take a look at whether we might be able to do it effectively here. We call for a Federal Reserve system, in part, because it is State-based; in part, also, because I think you have to have some very firm decisionmaking authority with the opportunity to have what we would call a circuit breaker, that is, Congress overriding those decisions should we find that we disagree with a position or a policy enunciated by the Federal health board.

I am troubled by your harsh assessment of the role that a Federal Health Board would make under those conditions. Could you elaborate a little bit more as to why you feel that way?

Mr. KIRKLAND. As we state in our testimony, that the national commission would negotiate rates of payment. Once those payment rates are negotiated, they must apply it to all payers, including government programs.

The commission should use the methodology that has been employed successfully under Medicare. We essentially call for the application of the Medicare approach: payments to hospitals on a DRG basis, with adjustments for facilities with special needs.

Payments to physicians should be on the basis of a resource-based relative value schedule with geographic adjustments as necessary. We believe that is the most effective and most efficient way. It is proven. It is based upon an approach that has been developed under a national health insurance plan: Medicare.

It is effective, and we think it is also cost-effective. The cost of the burden of administering 50 entirely different State counterpart bureaucracies I do not believe would be efficient.

I believe that the approach that we use is capable of taking into account and applying geographical or special situation circumstances that present a practical issue and that can be practically resolved.

Senator DASCHLE. Let me ask you. Lester Thoreaux, a couple of weeks ago, said that within 20 years no employer will be providing health care coverage in this country for one of two reasons: either they will have moved abroad to avoid the responsibility, or we will have come to our senses and eliminated that responsibility in this

country simply because we realize what a detriment to competition that is.

Yesterday, Dr. Paul Starr, in testimony, said, you know, the employer does not get into my private life in any other aspect. It does not get into my housing needs, it does not get into my grocery needs, my education needs, why should it get into my health needs? I would be interested in your reaction to those two comments.

Mr. KIRKLAND. There is no question but that the present system, or lack of system, in this country imposes extraordinary cost burdens on employers, far greater than those in other countries that have assumed some responsibility and they have undertaken and do provide universal access to health care.

Where the employer would move to escape that responsibility, if he moved to other countries that are at the same level of economic development as the United States, he would move to a country that does provide universal access to health care in a manner consistent with freedom, a market system, and democracy.

In Canada or to Europe, he would move to a place where he would be obligated to bear a share of the cost of providing that system. And the result of that would be that this cost would be lower.

The CHAIRMAN. Gentlemen, we will have to move along.

Mr. KIRKLAND. The lesson to be drawn from that is the way in which he can control those costs and be assured of the more equitable distribution of those costs, and, in effect, reduce the burden, would be to do what those other countries have done, which is develop a universal health care system.

The CHAIRMAN. Mr. Kirkland, I have others that want to ask you questions.

Mr. KIRKLAND. All right.

The CHAIRMAN. All right. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you. Mr. Kirkland, thank you very much for your comments on leadership. That gives me an excuse to thank you for the contributions that your staff makes to policy.

I broke in on Burt Seidman, and now Karen is doing as much work, or maybe even more than he did. And I think that contribution is immeasurable.

Even though we may disagree on outcomes sometimes, I just want to compliment you on your commitment and organized labor's commitment to debate this issue and keep it on the forefront.

I am going to ask you if you agree with this statement by way of national health policy. It happens to be something I believe in, and I am assuming many people would.

And that is, an ideal national policy ought to guarantee equal access to superior quality care for all Americans through some form of universal coverage. Would you generally agree with that?

Mr. KIRKLAND. Yes.

Senator DURENBERGER. And would you agree with the statement that we do not have that in the United States of America today?

Mr. KIRKLAND. Without question.

Senator DURENBERGER. That particularly we do not have equal access and we do not have universal coverage. There is no question

about that. We might debate quality, because, to some degree, quality is presumed.

But certainly we do not have equal access and we do not have universal coverage. So, the consensus would be that we, as Americans, need to have more than we now have. And the debate here is, how do we get it?

And one of the presumptions is that about the only way you can get it is either by spending more on the current system, which tends to exacerbate the cost problem, or to find a way to contain the costs or some combination thereof. Would you generally agree with that?

Mr. KIRKLAND. I agree with everything you have said so far, Senator.

Senator DURENBERGER. All right. Now, if I might ask you in terms of the containment of cost—I will not ask anything about taxes, unless you want to say that is the better answer—which is the subject of this hearing, do you have sort of a favorite target or two, or priority, perhaps, is a better word, that, as a nation, we ought to be dealing with in the area of cost containment?

Mr. KIRKLAND. Well, in terms of approach, I think we have a body of experience and an appropriate methodology that we can pursue. And that is the one that exists now under the Medicare program.

We do believe that a comprehensive approach with the approach that we strongly advocate and support, there is an essential role for all of the players in the system in the negotiation, the determination of the order of priorities in terms of cost control and the best approaches and methods of doing it.

We have ideas on those matters, but we believe that is what appropriately ought to be developed through this National commission on which all of the players and those more centrally affected by the system would operate.

Senator DURENBERGER. Well, I thank you. I appreciate that response.

Mr. KIRKLAND. Now, that is not inconsistent with the role for competition and for opportunities for experimentation with various approaches and methods of dealing with medical care issues.

Senator DURENBERGER. Right. And the frustration here may be that, depending on the length of time we have been here, that has been our specialty, is trying to do universal coverage using Medicare/Medicaid payment policy changes to get there. And we seem only to have exacerbated the problem.

In our discussion yesterday, one of the favorite targets was administrative costs, and people who advocate single payer systems liked the idea of cutting administrative costs.

And that has always puzzled me as a solution because I think administrative costs in the health insurance system generally are quoted as being 14 percent, 20 percent; big, big figures.

Well, by comparison, Medicare is only about 4 or 5 percent; Medicaid is only about 2 percent in terms of administration.

But the Medicaid costs in this country went up 40 percent from 1986 to 1989. They doubled from 1989 to 1992, from $61 to $127 billion. And, at this rate, they are going to be $400 billion by 1995. And Medicare has not done a lot better.

So, I just hope that as we all debate this issue, as we must, and discuss it—that is despite the fact that in my State of Minnesota, for example, Medicaid pays only from 25 cents to 42 cents on the dollar of charges. And Medicare pays like between 50 and 67 cents. I mean, we are under paying in both of those programs and the payments are still going through the ceiling.

So, the notion that somehow administrative arrangements or rearrangements are going to make it just does not seem to be the answer. And I will just conclude with that as a statement and hope we can discuss it further. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Mr. KIRKLAND. Measures to restrain cost and to negotiate whatever increases in cost are foreseen and that are necessary—I do not think that costs are going to be kept at zero in any segment of our society.

The problem is that there is no limit, no end, no foreseeable check on that escalation. Yes, costs have gone up under Medicare and under Medicaid. That is indisputable.

They have not gone up as much as they have in the private sector. They have not gone up as much as the cost burdens that we face in negotiating rates under our health insurance plans.

We have people in area after area in Local after Local who have not had wage increases for years because every bit of negotiated economic gain that can be achieved at the bargaining table has had to go into maintaining the existing level of benefits in the health plan. So, that clearly means that they are paying those costs.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. Thank you, Mr. Kirkland, and Mr. McGlotten, and Ms. Ignagni, for being with us. Everybody knows the system is broke and everybody probably has an idea on how we should fix it, which is a real challenge, of course.

Let me just ask your thoughts on one concept. I have met with representatives of labor on this. They tell me that two-thirds of all of the individuals in the United States have annual health care costs of $3,000 or less.

The concept of a medical care savings account whereby an employer would give to an employee a certain amount of money for that person to have in a medical care savings account.

It would belong to that employee. The employee would use it to pay his up front medical expenses, up to $3,000. If the employee lost his job or was transferred, that account would be that employee's account. He would be able to take it to the next job, hopefully, that he finds, and use it continue to pay his medical expenses.

The employer would use the rest of the money he would normally contribute to that person's health plan to buy a catastrophic policy for his employee to be used when his expenses exceeded, say, that threshold of $3,000. Do you have any comments on the concept of the medical care savings account?

Mr. KIRKLAND. Yes, I do, sir. And I think it is a diversion and a by-path, and a fruitless one if that is the kind of approach that is taken a way to resolve the problems we are talking about.

In the first place, if the trade union community, the well-intentioned medical care community, the medical association, the hos-

pital association, the business round table, management, generally, local chambers, all of us who have been spending so much time grappling with this problem, with the expertise available, cannot effectively deal with this on their own in the market system privately, how do you expect an individual to do it with an IRA?

It does not address any of these issues or problems and it is a shifting of the burden to the individual, that society generally has not been able to grapple with in its most organized and systematic approaches.

I think it would not move us toward a solution, in the terms of making it more affordable, but would rather compound and aggravate that problem. There would be inherently tremendous problem of adverse selection and many other foreseeable problems that we could see with such an approach.

It is a little bit like the small market idea. If you offered tax incentives, whether it is IRA or reimbursable tax credits to individuals, there are many employers who would abandon the group plans that they have now in place and shift that to the individual.

They would say, all right, you are taken care of through this individual approach, this IRA or tax credit approach. We do not have to deal with it anymore.

So, plans would be terminated. Plans would be terminated, just as pension plans are being terminated by employers to buy individual annuities. Companies then collapse and stick people with the bills.

And the net effect of that, then, is you have used governmental expenditures in the form of tax expenditures to subsidize employers.

You would use the income tax that people pay, because these things are not cost-free, and the general taxpayer is then subsidizing the employer to abandon his health plan. That is directly the reverse of the way in which we should be moving.

Senator BREAUX. Well, I thank you for the response. The only two comments I would add for the record is that the employer already deducts his contributions to insurance for his employee. He would have the same deduction, no more, no less, only the same.

And the second part of the package, which I did not lay on the table, is that there would be a mandate that the employer would still continue the catastrophic contribution to the plan. He would not be able to abandon the catastrophic over and above the contribution to the employee. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. Mr. Kirkland, let us assume a single payer plan in which the Federal Government sets the benefits, or some regional board sets the benefits.

And they say for everyone in this country, these will be the benefits under a single-payer program. The government collects the money and pays them. Would you presume that would exclude collective bargaining above that benefit level?

Mr. KIRKLAND. No. No, sir.

Senator PACKWOOD. So, you could still have a multi-tiered health plan in the country and the government would be the minimum level.

Mr. KIRKLAND. I think that is the case in most of the national plans that exist in Canada, in Great Britain, and other countries.

Senator PACKWOOD. Yes.

Mr. KIRKLAND. There is the opportunity for negotiating additional benefits above and beyond the basic insured package.

Senator PACKWOOD. I just wanted to make sure that we understood that. I want to go to Dr. Enthoven's plan at Stanford. We were intrigued with him yesterday.

What California is attempting to move toward, if he has his druthers, and I will separate the two, at Stanford they have a benefit plan for all of their employees, and it is a standard benefit plan.

They do not have four or five different plans. There is one plan. And then different providers bid on it. They have four HMO's and one preferred provider. But they have to provide the same benefits.

And Dr. Enthoven argues that this is where the competition comes in among the providers, and you do not have any variance in the benefits, so that they are going head to head with each other. And he claims it appears to work.

But, let us say that Kaiser, to cover an individual under the Stanford plan, they would say, charge you $125 per month, per individual. And another HMO charges $135, and the PPO charges $130. The most that Stanford will pay is the $125 for each employee.

If they want to go and opt for some other plan that provides the same benefits; maybe it is closer geographicals, maybe the HMO is located in your neighborhood, maybe the doctor you want to go to is in the PPO and not in the provider plan, they only will pay for the lowest plan.

And he would suggest that that should be the limit of tax-free payments for the employee. If you want to choose a higher paying plan than that, you pay for it. What are your views on that?

Mr. KIRKLAND. Well, in the first place, with respect to these approaches, none of these ideas are essentially new.

Senator PACKWOOD. There are not many new ideas, actually.

Mr. KIRKLAND. I remember many years ago some of our organizations—the UAW, for example, in its negotiations with the auto companies many years ago and pioneered in establishing the concept of free choice of plans and also in establishing and making certain that a group practice plan was among those choices. We have it with our employees.

So, these are approaches that have been in effect for many years. In some respects, the governmental plan for Federal Government workers is on that basis. They have a choice of a variety of different plans that compete.

Senator PACKWOOD. The difference, though, in the Stanford situation is all the plans provide exactly the same benefits.

Mr. KIRKLAND. Yes. Yes. That exists in some areas, and not in others. But I doubt that this represents the ultimate resolution of the problem we are dealing with.

Because the point that I want to make is that we have had these plans and similar plans, I can tell you, for at least 30 years. And they have not controlled the cost escalation in this country either in those places, or elsewhere.

Senator PACKWOOD. And Dr. Enthoven's argument would be is that we really have not had competition.

Mr. KIRKLAND. Well, we have had competition. We have had competition. And competition has not been sufficient to deal with it.

Senator PACKWOOD. On this single national cost containment program upon which there would be labor, consumers, management, government, and providers, for better or for worse, you are willing to say that you would accept the outcome of their suggestions as to cost containment, I think.

Mr. KIRKLAND. Yes, if we were a party to it. If the workers are represented. Yes.

Senator PACKWOOD. Are you assuming that the vote is like the Security Council, with a veto, or will this be a majority commission? [Laughter.]

Mr. KIRKLAND. No, no. Unfortunately, we are not familiar in our practice with such situations. That might be nice, but we do not have it anywhere that I know of. [Laughter.]

Senator PACKWOOD. Because I can honestly picture this commission suggesting co-insurance and deductibles that might be significantly greater than some of the union plans that now exist as a cost containment mechanism. And then I am not quite sure what position that would put you in.

Mr. KIRKLAND. We have strong views on that subject, sir, and we would assert them. That is one reason why we feel very strongly about reserving the right to negotiate with employers the efficiencies or limitations that might be incorporated in a basic plan.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Kirkland, I guess we have all concluded, having been involved with this for some time, that this is an incredibly complex area. And, for example, also there is some variations in what the statistics seem to say.

For example, it is my belief that the costs under Medicare have, in the past several years, gone up just as much as the health care costs nationally have been, about 12.5 percent.

And that our efforts, worthy though they might be on RBRVS, and the DRG's, and so forth, have not been that dramatic in containing the costs.

And, as Senator Durenberger pointed out, in many instances, of course, Medicare is not paying as much in the hospitals as a regular patient is.

So, I am not opposed to these suggestions, but it just seems to me that it has not produced the results that we hoped for. So that it seems to me that there has got to be some radical restructuring.

And, indeed, under Medicare it is a fee-for-service situation anyway which involves a lot of problems in itself. Now, your organization has had considerable experience in HMO's, and, indeed, was the founder of the first HMO in our State.

And we had some interesting statistics cited to us yesterday and this morning on the following: in the Kaiser Permanente system, they have 1.4 hospital beds per 10,000 of the population. Elsewhere—and I presume this is a national figure—it comes out four hospital beds per 10,000.

And the suggestion is that if we are really going to get control of the costs, somehow we have got to involve both the patient and the providers in an incentive system here, that there is some reward for them.

And I do not see that either in the single payer system, such as Canada, and, indeed, we had statistics yesterday that once you get by the savings from the single payer, which are dramatic and do exist, that beyond that, the costs have gone up just as much as they have in the United States.

In other words, you make your initial savings, but the Canadian per capita cost have gone up more than they have in the United States. And these are the statistics that we were looking at yesterday.

But, in any event, it has not been a solution. I guess what is worrying us all is that these costs are just going right off the chart and something is going to give in our country. If you are spending 12.5 percent of GNP on health care, and it is going up continually, you cannot keep it up forever.

Is there anything in your proposal that is an incentive for people to try and keep these costs down?

Mr. KIRKLAND. Well, I certainly think so, sir, to the extent that people themselves have anything to do with that.

There are two or three points I want to make about your comments. One, certainly Medicare and Medicaid costs have gone up. I do not believe, certainly within our experience, they have not gone up as much as the health care costs generally that we experience in the private sector.

Our experience has been that costs of existing health insurance plans and existing benefits that we face in negotiations have gone up something like 20 percent a year, which is considerably higher, I believe, than the cost increases in Medicare.

Secondly, I believe that the cost increases in Medicare and Medicaid are influenced by the environment of the general medical care escalation in the private sector. They are not immune from that, and I think it helps pull them up.

Then, as a further point, the differential impact, I pointed out that the plans that our people have succeeded in negotiating and are struggling to maintain bear some of these costs.

There is an element of cost savings in health care reform in making a system universal in the proper distribution and allocation of those costs that would save the system a considerable amount of money that exists now.

We have, for many, many years, been strong advocates of HMO's, group practice plans, of plans that emphasize early treatment, that provide comprehensive benefits rather than focusing on providing benefits only in the hospital or encouraging hospitalization.

We do believe that there is an element of cost saving in those plans in terms and experience that hospital use can be drastically reduced and controlled.

So, we firmly believe that there is a place within the universal health care system for competition, for experimentation, and for different approaches to these plans. We do not believe that people should be forced into one or the other.

Senator CHAFEE. I see my time is up. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Pryor.

Senator PRYOR. Mr. Chairman, in the interest of time, I have no questions.

The CHAIRMAN. Thank you. Senator Hatch.

Senator Hatch. Well, thank you, Mr. Chairman. Welcome to the committee, Mr. Kirkland. I appreciate having you here. I only have one comment that worries me a little bit about the current Health America approach, or play-or-pay.

Yesterday, the committee heard testimony from Karen Davis, who stated that health insurance currently accounts for about 12 percent of an employer's payroll, and she projected that to rise to about 23 percent by the year 2000. That is, it would nearly double in just 8 years.

And the bill introduced by Senators Mitchell and Kennedy and reported by the Labor and Human Resources Committee requires a 7 percent of payroll tax to be paid by an employer, unless the employer has a health benefits plan that meets certain requirements.

Now, I just want to point out that given the difference in costs of the employer, 7 percent versus at least 12 percent, my question has always been—and I do not expect you to answer it, I am just making this comment—why would an employer not simply terminate the plan and enroll his employees into the public plan?

And, then, what effect would that play-or-pay mechanism have on collectively bargained health plans that employers are currently paying for?

It bothers me, because I think the employers would rely on the existence of the public health plan to press for more give-backs, or the outright elimination of the employee health plan when the union contract expires and the whole wage and benefits package goes on the table.

So, these are some of the concerns that I have. I do not expect you to answer those today. I just want you to think about them. I am thinking about it.

I would like to do what is right here in the interest of the country and everybody. But it is so complex and so difficult, nobody is quite sure what to do. But those are the comments I wanted to make.

The CHAIRMAN. Thank you.

Senator HATCH. Thank you, Mr. Chairman.

Senator RIEGLE. Senator Hatch, would you yield, just as an author of our plan that you made reference to, we do not set a percentage in there. I know you used 7 percent. That may be an estimate that you have generated, but——

Senator HATCH. Well, you can not set 12 percent, I guarantee you that. I mean, there is no way you are going to sell 12 percent and not kill the small business community. So, all I have ever heard was 7 percent from Senator Kennedy, and others as well.

Senator RIEGLE. Well, we set no percentage.

Senator HATCH. I would say it is still going to kill an awful lot of the small business community. They cannot afford to do that.

Senator RIEGLE. Well——

Senator ROCKEFELLER. If the Senator from Michigan would yield.

Senator HATCH. And these points that I have made with regard to collectively bargained plans are certainly valid points, as somebody who has been concerned about those for years.

The CHAIRMAN. Gentlemen, could we get that debate between and amongst you at another time?

Senator HATCH. We will get there on the floor soon enough, I am sure.

The CHAIRMAN. I would like to try to finish up this hearing. Senator Rockefeller.

Senator ROCKEFELLER. I am being called on, or just to respond.

The CHAIRMAN. If you would like to make a comment.

Senator ROCKEFELLER. Mr. Chairman, my basic response, other than submitting a statement for the record, is a fundamental sense of apology and bereavement on my own part that I was out of Washington yesterday and just came back, so I have missed two of the most important hearings in my world of interest.

In responding to Senator Hatch, in the bill that we have been discussing, the percentage not only is not set in the bill, but it is specifically stated in the bill that only the Secretary of HHS can set that percentage of payroll tax.

And it has no congressional review; it is his decision alone. It can be changed by him. And the philosophy behind that is so that the cost of the public plan and the cost of private insurance are maintained in equal tension, in so-called exquisite tension so that there is not a temptation on the part of business, for example, to dump into the public plan, which would not be either in our interest, or certainly not our purpose, but to keep them in balance. And that is the sole responsibility of Secretary of HHS. The Senate or the House is unable to do anything to change that.

Senator HATCH. My point is, it would be 12 percent that people clearly cannot pay.

The CHAIRMAN. We have Mr. Kirkland here. Would you like to ask a question, Mr. Rockefeller? [Laughter.]

Mr. KIRKLAND. Keep going. It is all right.

Senator ROCKEFELLER. It is time for some mediation here.

The CHAIRMAN. We have a whole group out there waiting yet to be heard.

Mr. KIRKLAND. It is nice to have you so deeply concerned about our collective bargaining problems, Senator.

Senator ROCKEFELLER. I have been concerned for years, ever since I was 16 years of age, as a matter of fact.

The CHAIRMAN. Mr. Kirkland, Mr. McGlotten, Ms. Ignagni, we are very pleased to have you. Thank you for your contribution.

Mr. KIRKLAND. Thank you very much, Mr. Chairman. Thank you, members.

The CHAIRMAN. Let me say to the next witnesses, I want Professor Altman and Deborah Steelman, if the two of you would please come up. We will reconvene this hearing at 1:45 for the other two panels. I hope all will be able to be in attendance. I would ask the members to hold their round of questioning this time to 3 minutes each, if they will. Professor Altman, if you would proceed.

STATEMENT OF STUART H. ALTMAN, Ph.D., DEAN, HELLER GRADUATE SCHOOL, BRANDIES UNIVERSITY, WALTHAM, MA

Dr. ALTMAN. Well, good morning, Mr. Chairman and members of the committee. My name is Stuart Altman and I am currently the dean of the Florence Heller Graduate School for Social Policy at Brandeis University. I have also had the privilege to serve as chairman of your Prospective Payment Assessment Commission. But my testimony this morning is my own and in no way represents either of the groups or any other group that I am part of.

This is not a new issue for me, as it is not a new issue for you. I had the privilege to testify on this issue back in the mid-1970's when it looked like we might do something in the broad area of health care reform.

As I look at the statistics and hear the discussion this morning, I lament the fact that somehow I was not either persuasive enough or the clouds that formed to make public policy just did not hit in the right form, because the problems surely are much worse today than they were then.

I will not go through the litany of problem; you now know them well. You have heard them recited yesterday and this morning.

I want to focus, instead, just very briefly on two issues. First, as many of you know, I have long favored a mandated system through our employer-based system, which has now been modified, and is now, as you all here call it, the play-or-pay system.

I realize, as Senator Hatch has indicated in his previous questions, that there has been criticism of this system from two sources. For those who want to make sure that most employers and employees stay in the private sector; they are concerned about the tax rate.

Senator Rockefeller indicated that there is no specific limit. And, clearly, that is a key factor: What rate you put in. Now, I agree with Senator Hatch that if you make that tax rate too high you really would have a serious problem with small employers. But I do not believe that is an important problem, if you are willing to subsidize, not small—I want to emphasize, we should talk about subsidizing low-wage firms. There are lots of small firms out there of accountants, lawyers, and dentists that are high income. So, I think we are talking about low-wage firms.

Since the administration and other plans are willing to subsidize such individuals, we can subsidize them and can subsidize them to keep their rates low. But it is important that the tax rate be set so that we do not see 100 or 150 million individuals in the government plan.

On the other side, people criticize pay-or-play by saying that it just maintains our wasteful insurance system. Here, too, I think there are a number of provisions to put in place to make it less costly and not have all the money flow through the public sector.

I do not think that necessarily you would do a bad job, but you have other important functions to deal with. And, therefore, I continue to be strongly in favor of our mixed private/public system with its warts because it is the way we have chosen to do it, and I would rather see us modify what we have than throw it out.

The hearing this morning is about something I care very deeply about. Whatever financing system we come up with, I could not

agree more with you, Mr. Chairman, and the other Senators that have said that the cost of his system is just absolutely killing us.

No plan that we can come up with today can withstand the rate of increases that we are talking about. None. Play-or-pay, all-payer, single-payer, no-payer; 15–20 percent increases overall, continued growth two to three times the CPI is going to bankrupt us. So, we have got to get on with controlling these rates of increase.

I know yesterday you heard from my colleague, Alain Enthoven, about a very interesting proposals that he has been advocating for many years. It is a serious proposal. It should not be dismissed.

On the other hand, you have heard from Mr. Kirkland and others about the need for an expenditure board, the need for a governmental policy. Personally, I do not see these as being inconsistent. I think we need them both. This is not a trivial problem.

Some people would dismiss it, and I must admit, listening to the discussion we had earlier this morning, some people make light that somehow the forces of competition will just eliminate this problem. Alain Enthoven does not make that comment. I surely do not make that comment.

In my testimony I try to lay out a proposal which would maintain managed competition within a structure, but have over it a national expenditure board which has regional boards. Senator Daschle talked about the need for that at the regional level; I agree.

This national expenditure board would collectively be a deciding factor. I believe strongly that it should be set up like the Federal Reserve System, that is, away from the day-to-day operation of both the administration and the Congress, but where the Congress does have ultimate power to withhold their part of the funds.

If the Congress withheld its part, Medicare and Medicaid, that system would collapse. So, it is not like a separate national expenditure board is going to be in free flight.

We would have a national expenditure board. It would collectively say this country ought to shoot for 15 percent, 14 percent, 13 percent of GNP. This would translate into so much money per capita. We would distribute it to these regional boards.

These regional boards would establish the limits and say to managed care competition, fine, you can have up to an 8-percent increase next year.

Do your thing, if you are so efficient, so effective. If you cannot, you are going to have to find other sources of money. But, within that overall structure, managed competition can play out.

Now, what Alain does not talk about is the complexity of the current payment system. In my 9 years as chairman of PROPAC, I now can appreciate the complexity of our payment system. It is becoming a gigantic "Ponsi" game.

The cost-shifting is of the magnitude that some employers are paying 185 percent of the cost of the care of the people they insure, while others in some States are paying 56–60 percent.

Where in the managed competition would this be eliminated? It would not, unless we establish along with it a form of an all-payer approach.

Now, all-payer approach does not mean—and I want to emphasize this—that every payer has to pay the same rate. If a plan

could demonstrate that it is, in fact, using hospital care more efficiently than the others by having their people stay in the hospital fewer days, by not allowing every test and procedure that others do; if it is because of efficiency and not because of bullying tactics of the market then they could negotiate a lower rate.

But, if it is simply they go in and say, either you give me a 20-percent discount, or I am taking all of my patients away from you, leaving to the patients that remain the higher rate, I would not allow it.

And, by the way, I would not allow the government to use its bullying tactics either, because, basically, we are a bigger bully, collectively, than they are, if we wanted to use it.

On the other hand, I would not have, and would recommend you not allow the government to pay any rate the market establishes simply because it has established it. That would be to say to the government, if the rate is set at 25 percent of costs, well, then you will have to pay it. That would be saying we would give up any negotiating power.

What I am trying to emphasize is that this debate, between managed competition and some form of over-arching regulation, in my mind, has gone beyond where it is constructive. We have to get on with the job.

I personally think we should do it within an employer system, modify it, use some tax incentives if we believe we need it for low wage firms—and I believe we do—but, most importantly, get on with the job of cost containment

Here, I believe we have a responsibility at the national level to put together a total expenditure limit, and, within that, to have managed competition.

But I hope and I know all of you in this room share with me that we do not let 1974 be repeated; have a big debate about national health reform; and everybody, if they cannot get their own plan, pick up and walk away. Thank you very much.

The CHAIRMAN. We certainly share that concern.

[The prepared statement of Dr. Altman appears in the appendix.]

The CHAIRMAN. Ms. Steelman.

STATEMENT OF DEBORAH STEELMAN, ATTORNEY AT LAW, CHAIR, 1991 ADVISORY COUNCIL ON SOCIAL SECURITY, WASHINGTON, DC

Ms. STEELMAN. Thank you, Mr. Chairman, for the invitation to be here today. What I have before me are 11 volumes of the Advisory Council report that I must reduce to 5 minutes, so hang onto your hat.

The CHAIRMAN. All right.

[Showing of charts.]

Ms. STEELMAN. This chart depicts the rate of increase in health care costs and how significant it is. There are two important things about this chart.

Number one, we have to do two things to keep health care from bankrupting this country over the next 30 years. We have to increase the rate of growth in the economy and we have to reduce health care spending.

Those, however, I do not think are the most important things about this chart, because obviously are not going to let 31.5 percent come true. The most important thing about this chart is the magnitude of the change required.

In order to keep health care under 20 percent of our GNP by 2020, just an arbitrary goal, we are going to have to take as much out of the system as we currently spend today. It is change of unprecedented magnitude. Our legislative processes have never really addressed anything quite like this.

[Showing of charts.]

Ms. STEELMAN. So, the Council decided that a change of this magnitude has to have an incredibly strong public will to support it. We had many public hearings. We talked to over 1,200 people. We quantified our results in a poll.

But I would like to say that yesterday you had testimony even better than our report. Yesterday, your last witness distributed this document, "Faulty Diagnosis," and this is absolutely required reading. This is one of the best documents I have read to prove the points I am about to talk about.

If we have change of this magnitude that requires strong and sustained public support, a willy-nilly or wishy-washy kind of support is not sufficient to accomplish the task.

In our poll, we asked everybody how they felt about national health insurance, managed competition, employer mandates, universal catastrophic protection, and individual tax credits.

The little red bar signifies those people who felt very strongly about these ideas and strongly supported them. And, as you can see for all of those plans, it is less than 20 percent.

We then asked whether they would be willing to consider this kind of change as the change necessary in this country. And over 60 percent said they would be willing to consider this kind of change.

What that means is we have a public that is not very ideological about health care reform, that recognizes that there is a problem, that wants to understand what the best answer is. They want to understand what each of these proposals will mean in their own lives before they give it their full support.

I think this is a very critical issue relating to what Senator Riegle said earlier about leadership, the functions of leadership in health care are not being met today by anyone, in my opinion, in the public debate; not by academics, politicians, any of us, myself.

And the reason is—and this has been true for the entire century of health care debate—people and experts speak fundamentally different languages.

People say the problem is greed, fraud, waste, the system is unfair, it is scary, it should not be like this. They say, why should I consider sacrificing myself while there is so much fraud out there?

I think the GAO is going to release tomorrow a study that says there is $100 billion in fraud in our health care system. So, people sit back and say, why should I change my behavior if there is this kind of fraud out there?

Experts talk a fundamentally different language. Experts say the problem is an inherently inflationary reimbursement system, tech-

nology explosion, misapplication of resources. Experts have a whole bunch of mumbly gobbledy-gook that we talk about.

So, in terms of leadership, how are we bringing the American people into the debate in a way that we are talking with the American people, and the American people are communicating with leaders. Today we are not doing it, and I submit we have not in this century.

Again, the most interesting question about public opinion today is why are we still so mixed up, so confused after a century of debate on health care reform? A century. We started to talk about national health insurance in 1911.

Why are we still at that stage of the debate? I believe it is because we have yet to recognize the issues on this chart. We have yet to address the problems that people say are really the problem in health care, and then work through those problems so that they have an understanding of what the real problems are.

The public will alone is not enough. Public will can be misleading in terms of effective reform. We do have to know what we are doing. Cost reduction, in my opinion, requires true comprehensive reform. And, I will say, the kind of reform that I do not really hear talked about much.

Our debate on health care reminds me of the story of the guy who was crawling around under a lamp post one evening when the policeman walked by, and the policeman says, what are you doing under that lamp post? He says, well, I lost a $10 bill.

And the policeman says, well, I will help you look for it. Where did you lose? He says, well, I lost it over there. And the policeman says, why are you looking for it under the lamp post? He says, because that is where the light is.

We continue to focus on a subset of reform because that is where the light is. We continue to talk only about provider regulation or how we pay providers, because that is where the light is.

And I will not challenge the fact that there are definitely a few bucks under that lamp post. But there are a lot of bucks elsewhere that we are not talking about.

The Advisory Council was very, very clear that if we are going to have comprehensive reform, which we insist on immediately, we have to talk about everything: the financing system, the delivery system, the role of the individual.

Our delivery system is heavily skewed to acute and institutional care. We have no incentives for cost innovation. Why, for example, are 98.6 percent of American babies born in hospitals? It does not happen on any other country on earth. Where are the birthing centers?

We have no incentives for cost-reducing innovation. We cannot freeze our system in today's technology. We have to build in adaptability for the future. We have to talk about long-term care and home care.

And we have to change the role of the individual. I think largely the role of the individual right now follows the mushroom principal: they are kept in the dark and fed manure.

We have to turn the light on these things. We have to talk about choices we have. We can stop smoking to save an awful lot of money. We can eradicate substance abuse and save an awful lot of

money. Our expectations have to be for all of these things, reform in all of these areas.

Now, what is the road to success? How do we build a public will and how do we build truly effective comprehensive reform? I think, Mr. Chairman, and Mr. Chafee, I have to give both of you an awful lot of thanks in this area for your leadership, because I think you are embarking on just such a road.

The Advisory Council says, number one, acknowledge and address problems people want solved now. People need to know that this government can do something with common sense something that will help them now.

Deal with greed, deal with fraud, deal with waste, deal with the unfairness of the system. You can do it through many things. This committee has already started doing it on self-referring physicians, reducing administrative costs, common sense insurance practices.

In my business of six employees, I cannot buy insurance for my employees that does not exclude every single one of us for life for some condition or another. That is not common sense. That is unfair.

These things can be addressed, right now. Once we start talking to people about addressing such obvious concerns then it seems to me they will buy onto larger sacrifices and larger comprehensive reform.

And we do not think we have to wait for that time to find out what kind of structural financing reforms work best. We can try these reforms in the field and actually find out. We don't have to rely on guesswork.

Right now, the political debate is pretty much "Your plan stinks; mine is perfect." That does not teach people much. It does not teach us much. The council recommended that the Federal Government expend $3 billion, at least, in implementing Statewide prototypes on two levels.

Number one, to support the State innovations that are already out there. Oregon and Minnesota are classic examples. Number two, invest some money with some States where there are pockets of reform for other kinds of ideas: tax credits, managed competition. There are pockets of public will out there ready to take on larger structural reforms. Let us invest the money to make those things happen.

And, then, once we have built the public will and we have a better idea of what really works, we will be able to do the right thing at the Federal level.

And I think we can do this in short order if we put our shoulders together and really look at the questions around leadership; not so much who is right and who is wrong, but how do we bring the American people into this process.

The stakes simply are too high to make a mistake. That chart is not the only thing that keeps me awake at night, that first graph I put up.

The other thing is the fact that the baby boomers are going to start turning 50 in 1997. If we think the politics of health care are hard now, they are going to get impossible after the turn of the century. Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Steelman appears in the appendix.]

The CHAIRMAN. Dr. Altman, in listening to Professor Enthoven yesterday, I was intrigued by his idea of the managed competition of health care plans and HMO's.

And then I was listening to one of the other professors talking about single-payer and saying that these are compatible, and can be used with each other. I also got that inference from you this morning. How do you wed those two? It seems difficult to me.

The other part of the problem from Enthoven's plan that I get concerned about is the rural areas and how you take care of them when you do not have the competition of the HMO's.

Dr. ALTMAN. Well, let me start out by saying, that I support many aspects of managed competition. But I think you need more than managed competition. Whether it is an expenditure board or some kind of health council, there are many areas, like rural areas, that we are going to have problems with. We are going to have problems with getting more primary care physicians. We are going to have problems with urban areas.

So, I think just to count on managed competition as our sole vehicle for both delivering care and controlling costs, I think is asking too much of a valuable addition, but not the total system.

In answer to the first part of your question, I think it is important to separate the financing of the system from ultimately the delivery of care.

You can bring financing, the money, into the system either through the governmental totally, through employers and the government; or through employers, government, and individuals. How the money flows into the system is different than how the money flows out.

The Enthoven plan deals primarily with how the money flows out. You could have these organizational entities created either from a single-payer approach, or from an employer mandate. They are not inconsistent.

But, let me stress at the end, Alain's, or any other managed competition approach by itself, (a) is not strong enough, and (b) is not comprehensive enough to do the job.

If you want the rest of the country to look like California, I think you are in for some trouble. California is no bed of roses when it comes to health care costs. Its costs are rising. It has a high degree of cost-shifting going on.

So, if you put a spotlight on Stanford, or on one plan in southern California, it looks beautiful. Take a look at the whole State. It is not a bed of roses. Not that other parts of the country are, but I think there is more to this cost containment than you can do in managed competition.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman. Ms. Steelman, I was impressed with your grasp of the factors leading up to cost escalation. Would you elaborate on your study of the effects of future health care costs on the economy, which is, in my opinion, the kind of global thinking that I believe is lacking in the total debate we have here.

Ms. STEELMAN. Truly comprehensive reform has to take into account the Medicare program, the Medicaid program, VA, CHAMPUS. We also have to seriously prepare to adapt these programs to future needs.

We get sick very differently today than we did in 1965 when Medicare was enacted. We will get sick very differently 20 years from now than we do today. We will die very differently.

We will have a much greater need for home care, rehabilitative services, and long-term care. We have a tremendous need to invest in the kind of medical breakthroughs that will tackle Alzheimer's and those kinds of problems.

I am very concerned that if we freeze today's system in place with any sort of system-wide, federalized system, we will freeze a lot of dinosaurs in place. We simply have to be focused on more innovative approaches to future problems than the current debate currently allows for.

Senator HATCH. Thank you. Mr. Altman, in your testimony, you indicate that you share my concern about businesses dumping their health care programs and going into the play-or-pay public program.

Dr. ALTMAN. Yes.

Senator HATCH. And you indicate that that is a legitimate concern on my part. Now, are you saying that in order for this proposal to work, that the 7 to 9 percent payroll tax will have to be raised, plus a subsidy for those who really cannot afford it?

For instance, as I mentioned before, we heard from Dr. Karen Davis yesterday, who said that health care benefits are 12 percent of payroll tax today, and that they are going to rise to 23 percent before the end of this decade.

Now, it would seem to me that the play-or-pay tax rate would really have to be exorbitant to not make it attractive to businesses to join the government plan. Could you comment on that? And let me just add one other thought to it, too.

I am concerned about the impact these higher tax increases have for small businesses, since almost 90 percent of all the small businesses or all of the small firms employ fewer than 20 employees. And many are operating on small profit margins, often grossing less than $30,000 per employee.

Now, that does not seem to me to allow a lot of room for providing insurance or paying higher payroll taxes. Could you comment on that overall set of questions?

Dr. ALTMAN. Yes. As I indicated in my testimony, I do believe if we are unmindful of this issue, it could be a serious problem. I do not believe it is a problem that cannot be solved. Now, I do not want to get into a numbers game. I think Karen's numbers are too high.

Senator HATCH. Can you give us some indication of how we might solve it.

Dr. ALTMAN. Yes. Well, I do believe that tax rates should be higher. And we are going to have to look at it. As Senator Rockefeller and Senator Riegle said, they did not put any number in there plan.

I think the 7 percent came from the original Pepper Commission, which, unfortunately, is now aging quite rapidly in terms of when

it was estimated, and inflation has gone on. So, I do believe we need to take a look at that number.

Second, if we are serious—and I believe we should be—about making sure that small employers—I am sorry, low-wage employers—can pay the bill then I think we should help them. That is what the President's plan is going to do. It is going to provide subsidies for low-income people.

Let us use the President's proposal, link it back in with the employer mandate. These plans are not totally inconsistent with each other.

So, I would use part of the President's plan to help out on low-wage workers. But, it is an issue that, if not dealt with, would leave, in my view, too many people being put into the government system.

One last comment. There was recently a poll done of employers that asked them, if, in fact, it was cheaper to put your employees in public plans, would you do it? And most employers said no. They do not want to do that.

They do not want to do it for three reasons. First of all, with all due respect, they do not trust the government that it will stay cheaper. I do not understand that. Two, many of them believe——

Senator HATCH. I do. I understand it.

Senator PRYOR. Dr. Altman, we do have to conclude this, so we will go forward.

Dr. ALTMAN. All right. I apologize. Anyway, there is no reason why every employer is going to drop, even if it is slightly more expensive.

Senator HATCH. Mr. Chairman, I want to say I appreciate his candor. I think he has been very candid about this and we may differ on the better way to go, but I respect you, sir. I just want you to know that.

Dr. ALTMAN. Thank you.

Senator PRYOR. Thank you, Dr. Altman. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. I was very interested in what was proposed yesterday by Dr. Enthoven and one of the points that Alain made was that, under CalPERS they are able to hold down the costs for that group, and, indeed, they had some recent bids come in where some of the HMO's have offered reduced costs. You were not here for his testimony yesterday.

Dr. ALTMAN. I have read it. Thank you, sir.

Senator CHAFEE. Yes. And some came in at 5 percent, between zero and 5-percent increases. But I think Dr. Enthoven does stress that really to have the system work, everybody has to be insured.

In other words, what distorts it is that many in California are not under the CalPERS system, or the Stanford system. What is your thought on that?

Suppose you had a State where all of the providers were under this system, or else everybody was under this HMO type of system where all the HMO's or Preferred Providers all provided the same basic services. And that is another part of his plan, that the package had to be exactly the same. Now, what do you think of that?

Dr. ALTMAN. Well, I am not opposed to it, but I do not think it should be the only thing we do. It just is not enough. So, fine. We should have competition. It would be nice for all the plans to look

exactly alike. I personally do not think we have to put everybody in quite the same straitjacket.

But that type of system has potential and has been shown to be effective. But, as I said, I do not think it is enough. It needs to have some over-arching limits imposed on it to say you, the country, cannot exceed next year more than 5 or 8 percent increase in expenditures and you manage up against that budget constraint.

Second, I do not believe we need to be as tough on the tax changes he would put in there. I do not think we need that. I think if we, in fact, had the same payment, people would sense the difference and make their choice. It would be a very unpopular thing for you to do politically to tell Americans that are already paying this price that they are going to lose their tax deduction.

Maybe in the future we may want to do that, but I think it will submarine that plan before it gets going. So, generally, I favor his approach. It just is not enough.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator PRYOR. Thank you, Senator Chafee. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. I will ask each of you the same question. Back in the 1970's—in fact, I think, Stuart, when you were last before us you were talking about this, that in the early 1970's there was a real chance for health reform, and President Nixon wanted to see it happen. And what happened was there were a lot of folks in Congress that came up with their own special ideas of how reform ought to be, including cost containment, and whatever else.

And that, as so often happens, people, when they want to vote their choice, their choice is their own plan and their second vote is, I am against anything else, which is, I think, what is happening now. And it is, of course, terribly tragic.

I would like to ask both of you where you think that the main proponents in all of this, that is, the President, some of the really only two or three types of programs here, and our interest groups, where people have to give, philosophically; where they have to give, not get, all of what they want. They are all locked up in a negotiating room, and God will them to come out with a solution.

What are some of the examples of where people would have to give or recede from their position so that the collective result could be a plan that works? Do you understand my question?

Dr. ALTMAN. You had to live with it.

Ms. STEELMAN. I think the premise of your question is off the point. And, Senator, you know how much I think of the work you have done here. But your question raises the whole point of my presentation in terms of the differences in the leadership and the people. The place where reform will come from in this country is the people's will. It is not interest groups locked up in a room.

I, for example, was locked in a room with interest groups for 2½ years as the Chairman of the Advisory Council, and there was not one iota of give in terms of accomplishing a national agenda. There was a lot of give in terms of learning and understanding what we did not know. There was a majority of our council——

Senator ROCKEFELLER. If I could interrupt for one moment.

Ms. STEELMAN [continuing]. That did reach the conclusion that the process I described in my testimony was the best way to get the answer to that question.

Senator ROCKEFELLER. But that is a fascinating assumption. You are saying it is like the American automobile industry saying to Americans, whatever you want, we will produce. The Japanese automobile industry decided what it wants to do because it is in the leadership position, and then it becomes the consumer's will.

Are you saying that we simply wait until the people come forward with enough rage? I mean, how many Senators have to lose their seats before we do this?

Ms. STEELMAN. No. The rage you are talking about is not directed toward the enactment of a specific reform. It is directed toward the waste, greed, fraud, and unfairness in the current system. The so-called consensus on national health insurance, the poll you always read that says 70 percent of people want national health insurance, is a house of cards. The first gust of reality blows it away.

The Japanese produced the Miata, even though it was designed by an American car designer, because the Japanese do know what their customers wants much better than American car manufacturers know what their customers wants. I am saying our customer right now is stuck in that mode: greed, fraud, waste, unfairness. Address these concerns and you will sell a lot of cars.

Until we address these customer concerns and then provide the leadership to take our customers through the larger public choices to develop a public will toward the enactment of specific reforms, we will continue to make the mistake we have made every time we have debated national health insurance in this century.

Senator ROCKEFELLER. Stuart?

Dr. ALTMAN. Well, I agree with those, but I disagree with waiting. It does not match up with her first chart at all. The first chart is a crisis, and the other one will take 25 years.

Ms. STEELMAN. The other one could take much quicker than the process we are on now.

Dr. ALTMAN. Well, but I think the Senator has pointed out that we need to move forward, but I do believe that these are the issues. I think an expenditure board type approach would deal with the greed, waste, fraud, and the kind of proposals we are dealing with.

I think the idea of matching up some of these, the President's proposal in terms of helping low-income people directly by the government, matched up with an employer mandate, would eliminate much of the problem of the small employer issue.

I think the idea of making those markets work fairly, in terms of making them work in terms of having nobody denied coverage is the right way to go.

So, if you took yesterday's testimony, and I almost said randomly put it together, but let us assume we have a little better smarts, I think in yesterday's testimony no one plan may have all the right answers, but collectively I think there is enough to fashion an acceptable plan. It would be nice to wait for the people to tell us what they want. I think we will be waiting a long time.

Senator PRYOR. Dr. Altman, technically the time of Senator Rockefeller has expired. However, because he got here a little late, and because he is such an expert in this field, and because this dis-

cussion is so interesting, I am going to extend him 5 more minutes so he can ask more questions. Sir, go ahead.

Senator ROCKEFELLER. Well, I just want to make one comment, Mr. Chairman. It is profoundly important, it seems to me, that if we say that we have to wait for either an amount of rage which is equivalent to suddenly the American people beginning to understand everything from asymmetrical transition to RBRVS, I think we are talking about a good 50 years.

I think this is an area in which the American people are classically saying to their government leaders—and not to the State leaders, but to their government leaders—the Kaiser Family Foundation, they want, expect, and demand that the government take the lead on this.

And the whole concept of waiting until the people understand everything about it—I have a theory, Mr. Chairman, that I will end with. We did catastrophic health care in this Congress, and it was superb. It was a great bill. We refused to repeal it in the Senate. Seventy-three Senators voted against repealing it. But we could not stand against the House, who insisted on repealing it.

Some of the people who fought hardest for catastrophic health care in the house became, then, for a period of time a number of years afterwards the most timid in advancing reform because they had been burned.

And I think any of us who take on commissions and do whatever we want in the exercise of leadership, if the answer comes back that you could not get the consensus, that you could not get what you wanted, therefore, let us pull back and wait until the American people push us forward, I think that is the opposite of leadership.

Ms. STEELMAN. I did not say that once.

Senator ROCKEFELLER. I think what we do is that we go right at it. And the perspective on health care is the same as the perspective on trade a number of years ago.

Trade has become an overwhelming issue. In the 1984 campaign, it was not even discussed in any debate at the Presidential level. It became an issue all of a sudden, and overwhelmingly complicated. This is much more complicated.

Health care has only recently become an understood, established national crisis where people are going crazy. And for us to say that somehow we have to back off and wait for the people to give us direction, it seems to me, an extraordinary absence of leadership.

Ms. STEELMAN. I did not use the word "wait" once. And my chart does not imply inaction. It implies action that will get to a consensus faster, I submit, than the current purely political and theoretical debate. And we will know whose process is more effective 10 years from now.

Senator ROCKEFELLER. But you are giving all kinds of reasons and excuses for not acting.

Ms. STEELMAN. I did not. I said we have to act right now on each of those elements. And we have to act on comprehensive reform. I did not use the word "wait" once. I am very sincere, Senator. I do not want to pick a fight.

Senator ROCKEFELLER. I know you are.

Ms. STEELMAN. We cannot wait. That is why I always start out with that first chart. Humongous change is required; change that

has to come from the gut. We have to build the gut in the American people.

And all I am saying—and do not take it from me, read "Faulty Disgnosis" by the Public Agenda Foundation. There is a way of leadership that will build that gut, and there is a way of leadership that will produce political paralysis, like we have every other time we have debated this issue in this century. So, I am not recommending wait.

Senator ROCKEFELLER. Mr. Chairman, I will just close with this. In the second World War when we lost the Philippines and Indonesia, the United States had no synthetic rubber. There was only real rubber and it came, a lot of it, from those countries, and we needed that for our Jeep tires.

Nobody knew how to do synthetic rubber. But when we lost those islands, we were in the middle of a war. In 6 months, we had invented synthetic rubber. The crisis is what drives people who care about this issue to do something about it. It happens to be us in the government, Congress and the White House, who are meant to do something about it. I think it is a simple point.

Senator PRYOR. Senator Rockefeller, thank you. In a moment, I am going to ask a few questions. Then, if you have one or two more, I would be glad for you to ask those.

Ms. Steelman, if you were sitting down with the President of the United States this afternoon, he had called you over to the White House and said, Ms. Steelman, tell me what to do about our health care crisis, what would you tell him?

Ms. STEELMAN. Exactly what I said to this committee.

Senator PRYOR. All right. You would tell him not to wait?

Ms. STEELMAN. I would say exactly what I said to this committee.

Senator PRYOR. Pardon?

Ms. STEELMAN. I would say exactly what I have said today. This is how I feel about this issue.

Senator PRYOR. Is this administration waiting, or is this administrating acting?

Ms. STEELMAN. Well, as you know, I am a private citizen. I am not a spokesman for this administration.

Senator PRYOR. But let me remind you of something, and remind myself of something, actually. I have read over your past, your very distinguished background.

You have been in the very, very highest echelons, served as Domestic Policy Director for the George Bush for President Campaign, Associate Director of Human Resources, Veterans and Labor, the White House, Director of Intergovernmental Affairs.

Very, very few individuals ever come before this committee with that number of credentials, the closeness and the association with power as we relate to and understand power. So, I look at you as a person who has had the ear, and probably still has the ear of the President of the United States. Is that correct? I mean, is he going to accept your advice?

Ms. STEELMAN. I have conversations with the President which, of course, I do not discuss publicly. The administration has a proposal that is somewhat different than the Advisory Council's. I think that is clear.

Maybe I can make a point here. When I left the campaign in 1988, the only thing I asked to do was to Chair this Advisory Council. I did not ask to serve, nor did I want to. And the reason being because I felt I needed to learn more to develop a course of action in health care reform.

My 2½ years on the council was very wisely invested, and resulted in these documents. We released our report on December 19. I briefed many members of this committee, including Senator Rockefeller, and I might add, I did so before I briefed the administration.

These are real recommendations designed to address an enormous challenge, a challenge that will last 20 years. If we get off on the wrong foot now, my children are going to be penalized. I do not want that to happen. That is why I am here. That is what I would say to the President.

Senator PRYOR. Well, Ms. Steelman, with all due respect, I had a hearing back in my home State a few weeks ago. In fact, I had three of them. I had over 1,000 people at each one of them in various parts of the State. It is on health care. It is an explosive issue.

People are bewildered, they are perplexed, they do not know what to do. They do not know how to pay for their health care costs. They do not know, a lot of them, how to get access to the health care system.

And I think really the best response I ever had during those 3 days is each day when I opened up and I said I am tired of addressing problems, I am ready to start solving problems.

With all due respect, I think what we are doing right now, not necessarily just in this hearing, but even in this commission report—and I know there are a lot of beautiful new books out there that you are about to give us—we are addressing problems. We are not providing comprehensive solutions to these problems.

Ms. STEELMAN. I respectfully disagree.

Senator PRYOR. All right. Let me ask this. Did the Advisory Commission on Social Security—and I am going to get into my subject area, now, pharmaceuticals—accept the fact that prescription drug costs for three out of every four elderly people today is their number one out-of-pocket medical expense? Did you address that?

Ms. STEELMAN. This council charter, which is explained in my written testimony, was extraordinarily broad, as was our membership. We addressed issues of family financial security over the next 30 years. We addressed pensions, savings, investments, Social Security, Medicare, Medicaid, and disability payments. We had a very broad charter. Our membership included representatives of various consumer, business, and provider interests. Dr. Cooper of the Upjohn Co. was our representative from the supplier community. As you know, I have pharmaceutical clients. I did not represent them or any other client in my advisory council work.

The reason we focused on health care reform was because we felt that that was the second most significant threat to the future of the economy. We believed that the slow growth in the economy was the most significant threat.

We felt that the economy has to be the number one concern, because if we do not grow this economy there is no way we can deal

with consumer and health care demand and the important public investments in education, infrastructure and defense.

So, we felt that health care was the most significant threat to American families. And, in that context, we dealt with many concerns, of which pharmaceutical coverage was one. Coverage, payments, price of pharmaceuticals were discussed as well as such issues relating to hospital, physician, and other services. We did not segregate out any particular sector for unique treatment, as you have done.

Senator PRYOR. Did you come to any solutions or conclusions as to what we should do in cost containment with regard to pharmaceuticals?

Ms. STEELMAN. Again, I will say, on cost containment, we felt that you have to deal with problems people think are problems first. Otherwise, they do not trust you and they are not going to follow you. And that is the legacy of 50 years of debating national health insurance in this country. That is irrefutable.

Senator PRYOR. Well, we are back in this rut again.

Ms. STEELMAN. It is not a rut.

Senator PRYOR. You are addressing problems again. Where are the solutions? You are not talking about solutions, you are talking about problems. Every chart you have is a problem, it is not a solution. You have one solution. On your last chart you say, do the right thing.

Ms. STEELMAN. Yes. Let me tell you about my solutions. If you will read any of these documents; if you would have read the release on December 19; if you would look at any of these things; if you ask me to sit here in 5 minutes and give you 11 documents and 2½ years of work in 5 minutes, I will tell you it cannot be done. If you want to sit there and criticize me——

Senator PRYOR. I am not criticizing you.

Ms. STEELMAN [continuing]. For not having, in 5 minutes, all of my solutions, I would be happy to shut up and sit here.

Now, if you want me to go through insurance reform, and medical malpractice reform, and school-based insurance, and community health centers, and rural caregivers, and cost containment on a global basis, and how the Federal Government ought to invest in that, then I will be happy to come to your office, sir, and talk about it. Because we have solutions.

What I am talking about is a way of leadership that will accomplish something, not stalemate us in a political diatribe like we have for 50 years.

Senator PRYOR. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Debbie, I have enormous respect for you, and you know that.

Ms. STEELMAN. And the feeling is mutual.

Senator ROCKEFELLER. Yes. I know. I know. I think in Chicago not long ago, an 8-year-old kid in one of the schools shot another 8-year-old kid with a gun.

And, on the National Commission on Children, Dr. Berry Brazelton used to say that the cocaine baby who is born at low birth weight today will meet your child on the streets tomorrow. So, I am simply reinforcing what you said. We have no time, except to move forward.

The road to success—and I am trying to buttress the Chairman's point of view here, because I understand that you want more to happen than is happening.

And I know that you are in a difficult situation. You are credited with telling the President what to do, you are not really in a position to be able to do that. It is a very frustrating situation for you.

But when you say, first we have to get rid of greed, fraud, waste, and something called unfair administrative costs, whatever that means; common sense insurance practices, by which I do not think you mean community rating, I think you probably mean, what, small group insurance?

Ms. STEELMAN. Right. Insurance reforms.

Senator ROCKEFELLER. Small group insurance.

Ms. STEELMAN. And other insurance reforms, not just small group.

Senator ROCKEFELLER. Yes. Common sense legal reform, medical liability, hospital fraudulent billing. It is a very light tap, it seems to me. There are 66 lawyers in the Senate. I have been trying to get product liability through the Senate for, I think it is 7 years. There are 66 Senators. I am not holding my breath.

So, I have to deal with that real world. Malpractice reform is incredibly important. It is also no more than 2 percent of the cost problem. I do not know what administrative costs are, but I think a lot of us agree that if you did everything possible that you could, well, for example, if you had a single-form billing for all insurance companies you would save, over 5 years, $9 billion. Well, that is nice, but it is only a small part of total health costs.

Self-referring physicians, I agree with you in some places, and in other places I do not. But whatever it is, I do not think it turns out to be an enormous amount of money.

Hospital fraudulent billing, I do not know exactly what you mean by that. I just want to come back at you that we do not have the time to create the people's trust of us because we have done something which they are angry about.

Because, one, even if we are able to do it, I am not sure the people will know that we have done it because the cost of everything keeps going up anyway, and, therefore, how are they meant to know; do we issue a bulletin which they suddenly believe?

So, let me ask you. If you had your flat-out wish list on things that you could do right now, that you are emperor, that you could do right now on cost containment, what would you do?

Ms. STEELMAN. Senator, I must reiterate the point that I think is most important, because I still have evidently not made myself clear.

People will not make the sacrifices necessary to achieve real cost reduction-notice I say reduction, not control—until we address the issues that they think are important.

Senator ROCKEFELLER. Good. I grant you that.

Ms. STEELMAN. I just want to read you——

Senator ROCKEFELLER. Now, please, Debbie, because of time and all the other panels, I will grant you that.

Ms. STEELMAN. Let me just read one part.

Senator ROCKEFELLER. I am not arguing with you. Let us say we have done it. They trust us. What are you going to do about cost

containment? What is on your wish list? We have gotten rid of this stuff.

Ms. STEELMAN. Well, number one, one of the things I want to do is eliminate tobacco use in this country; I want to eliminate AID's; I want to eliminate crack babies; I want to eliminate low birth weight babies; I want to eliminate violence and gun shot wounds. We spend more on gun shot wounds than we do MRI's in this country.

If we do that, would you like to guess, per capita, how much we would take out of our health care system, per capita? $700. We would spend barely more than they spend in Canada. I want to do those things in cost containment. I want to have insurance reform.

I believe in the managed competition school. I do not believe a national commission, particularly one modeled after the Federal Reserve, which the best book ever written about it was titled, "Secrets of the Temple," because they meet in secret and make secret decisions.

And their decisions have nothing to do with public will or family behavior. I think a commission like that is a false hope, at best.

Senator ROCKEFELLER. I am not asking you to say what you do not like, I am asking you to say what you do like. If you would not have that kind of adjurement approach, or whatever, the Federal health expenditures for it, then what would you do to bring about strong cost containment?

Ms. STEELMAN. Modify the delivery system, modify the financing system, modify the role of the individual. The role of the individual means take care of yourself and eliminate all of those problems, and let us spend some time debating those social problems.

I say, praise God for Lou Sullivan, even though I know it is not cool to say Dr. Sullivan has done the right thing. He does not play Washington footsie as well as the rest of us.

He has done the right thing on the leadership of the role of the individual. I say change the incentives for the individual.

Senator ROCKEFELLER. Market-based.

Ms. STEELMAN. Let us talk about the individual. Expose the incentives. Expose the connections. For example, Medicare beneficiaries right now believe they pay for it all with payroll taxes, and yet 38 percent of Medicare is paid for by general revenues today. Expose the connection so people know what they are buying.

Require knowledge of individuals. I do believe that economic incentives can be brought into play to lower costs by individuals. All the prevention and individual awareness is absolutely critical, yet we never talk about it.

Senator ROCKEFELLER. Debbie, that is what your report says. That is all that your report says.

Ms. STEELMAN. This is what I believe, Senator.

Senator ROCKEFELLER. I said wish list. You could not get everything you wanted in your report. I have read your report. I know your report. Wish list.

Ms. STEELMAN. This is my wish list, Senator.

Senator ROCKEFELLER. That is it? That is the extent of it?

Ms. STEELMAN. I want to change the delivery system. For example, why do we not have birthing centers in this country? Why do we not reimburse midwives? Why do we not reimburse lower cost

caregivers? Why do we not reimburse lower cost settings? Why have we no incentives for this kind of thing? Rate regulation will not do it. We have seen that in Medicare. We have to make these changes. Why do we not have more home care?

In the financing system, yes, we have to have managed competition; we have to have bigger pools; we have to allow reform individual insurance as well as the small employer market. It is all of a piece. You cannot just point to one thing and say, oh, that is what I wish for, that one thing would do the whole job. It is not that simple.

And, I have to say that the more I learn about health care the less I know, which is one of the reasons I want to see, at the State level, what really works best.

I may be dead wrong about rate regulation. It may be the best thing since sliced bread. A cost containment commission may be the best thing since sliced bread.

I would like to see that in the State of New York, or the State of Rhode Island, or the State of West Virginia, and I would like to see just 2o or 3 years of that.

I would like to see the implementation flaws, the design flaws, what screwed up, what went right. I could be dead wrong in my own thinking.

I do not think this debate will be over this year, or next year, or the next year. The changes required are too large. Why can we not proceed with the States to learn something real? Why can we not learn something? What is wrong with saying, let us learn something? I could be wrong; or you could be wrong.

Senator ROCKEFELLER. Dr. Altman. Mr. Chairman, you cut me off at the pass, but I would like to have Dr. Altman respond to what Ms. Steelman has said.

Dr. ALTMAN. Wow. [Laughter.]

I mean, it is hard to be against anything she is for. The problem I have is all the things that she is against. So, I would want to see all of the things that she has suggested done. They are really good things. They need to be done.

I am also in favor of experimentation at the State level. I think we can learn a lot from that. I just believe that we have also learned a lot over the last 20 years that we have not done, and it is time that we do it at the Federal level.

Now, maybe I am going to be dead wrong too, but I do believe that we can put together what she has recommended, but move forward with this expenditure board.

Now, the Federal Reserve Board, I mean, that is an unfair call about whether it is a secret society. The only reason for talking about a national expenditure board in that context was to, one, suggest that it be separate from the day-to-day operations of the government, and, two, to have it regionalized. That is all.

If you want to have it open to the public, if you want to have it selected by the way Mr. Kirkland says, I think that makes sense. The only reason for using the Federal Reserve Board concept is to get it outside of the day-to-day operating arm of the government. That is, in my view, very important. And, second, it should be regional.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator PRYOR. Senator Rockefeller, thank you. Now, I have one final little series of questions here. Ms. Steelman, you kept, during your presentation, talking about listening to what people want.

And when we listen to people, you say that they think that the system is consumed with fraud, greed, waste, et cetera. Let us take greed. Let us go down the list. Are doctors greedy?

Ms. STEELMAN. People think doctors, lawyers, hospitals, pharmaceutical companies, insurance companies, and everybody is greedy.

Senator PRYOR. All right. Are they?

Ms. STEELMAN. I think greed is a part of human nature, but that does not mean that we can solve enough through addressing greed to get at that chart.

My point is, we can not, by simply addressing people's concerns, address the magnitude of this change. But you have to start where they think the problem is.

Senator PRYOR. For the last couple of years or more, I have referred to the pharmaceutical manufacturers as greedy. Are they? Am I right or wrong?

Ms. STEELMAN. I was merely addressing—again, please read this and then let us get together; let us have a beer.

Senator PRYOR. I read it yesterday.

Ms. STEELMAN. Then you know what I am trying to say. That is what people think is the problem. Experts like Stu and others——

Senator PRYOR. I am asking what you think. You are an expert in this field. You are the Chairman of this commission. You were appointed by the Secretary of HHS. We are listing to you as an expert. Are the pharmaceutical companies greedy?

Ms. STEELMAN. Well, my expert opinion on pharmaceutical companies is they provide one of the best avenues to address some of the problems of the aging society that we know; that our patent system in this country is very different than other countries; that because pharmaceutical expenses are generally out-of-pocket, people feel these expenses much more than they feel expenses that are covered by insurance. These are the kinds of considerations experts discuss. I believe that people see greed everywhere; that there is no endemic quality to this industry that is different than any other industry or any individual.

Senator PRYOR. Is the fact that we pay in this country the highest prices of any industrialized country for American-produced prescription drugs, despite the fact that we provide the pharmaceutical industry with R&D tax credits, marketing writeoffs, billions of dollars in tax credits for manufacturing drugs in Puerto Rico, multi-year patents and with NIH research grant support, does that say something is wrong with our system?

Ms. STEELMAN. Yes. And, as you know, patent lives on drugs are very short because of the approval time at the FDA. No other country has that kind of system. No other country uses genericism as a cost containment device.

Many other countries will negotiate a guaranteed profit to the pharmaceutical company over the life of that product, which is longer than the life of the product in the United States, that is in excess of the average full like profit associated with many of U.S. pharmaceutical products.

Senator PRYOR. All right.

Ms. STEELMAN. So, yes, I think there are a number of problems.

Senator PRYOR. Have you ever thought about this, or the commission ever entertained this, because your commission on Social Security deals primarily with elderly people and people who are about to be elderly, like myself. [Laughter.]

Now, have you ever thought about this: what about us going over to Spain, France, and even up into Canada where they buy their American drugs. This, by the way, is a buy America plan.

To go to Spain, France, Canada, Italy, Belgium, anywhere, and buy our drugs at 50–60 percent less and bring them back and sell them to our people and still save half? Is that a good idea? What is wrong with that?

Ms. STEELMAN. Well, I think it would add to administrative costs.

Senator PRYOR. You mean the airplane ticket? Why would it add? Look, how can they sell these drugs so much cheaper there?

Ms. STEELMAN. They have a patent life that is about twice as long; they do not have genericism as a cost containment device; and they negotiate rates that last longer over the life of the product than they do here.

Senator PRYOR. Well, I am not——

Ms. STEELMAN. And I think we have to address all those problems. I also think that——

Senator PRYOR. Well, once again we are addressing problems. That is all we do around here, is address problems. That is all we do.

Ms. STEELMAN. I wish that were what we get around here, sir.

Senator PRYOR. That is all we do is address problems. No wonder the American people have lost confidence with us. Ms. Steelman, I have no other questions. I thank you. Dr. Altman, I thank you.

Ms. STEELMAN. Thank you.

Dr. ALTMAN. Thank you.

Senator PRYOR. This hearing will resume at 1:45.

[Whereupon, the hearing was recessed at 1:10 p.m., to reconvene at 1:45 p.m.]

AFTER RECESS

The CHAIRMAN. This hearing will come to order. I would like to have Mr. Richard Davidson, president of the American Hospital Association; Dr. Gerald Keller, vice president of the American Academy of Family Physicians, from Louisiana; Dr. Gerald Schenken, member of the board of trustees, American Medical Association, Omaha, NE. We are very pleased to have you.

Dr. Davidson, why do you not proceed?

STATEMENT OF RICHARD J. DAVIDSON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. Davidson. Thank you, Mr. Chairman. Good afternoon. I am Dick Davidson, president of the American Hospital Association. We appreciate the opportunity to appear before you today.

In our view, health care reform is essential and it is time to act. We are anxious to help you advance new public policy with one focus on one winner, and that is the patients and the populations that we serve in our communities across the country every day, 24

hours a day. We think that is where health care reform ought to be focused.

Today we want to focus on three points with you, Mr. Chairman. First, our view of some of the reform proposals that you have been talking about. Second, the need to reinvent the way health services are delivered in America because we do believe it is time to reinvent the way we do what we do; old strategies are out of touch and out of date.

And, third, the AHA's vision of a newly-organized delivery system to achieve our Nation's twin goals of universal access to health care for all Americans, and also at an affordable cost.

Let us talk, first, about the reform proposals before the Congress. I guess we have had a chance to look at about 40 different reform proposals, Mr. Chairman.

And all of the reform proposals before the Congress seem to have two principal objectives. One objective is to expand access to care for more Americans, and the second objective is to contain costs; in essence, to do more with less.

And if we have been struggling through our discussion of how it is that we contain costs in the current environment and then think about expanding access into the same environment, one wonders whether this is not a contradiction in terms; that how can we do both of these things, expand access and contain costs?

Looking at access, in our view, expanding access to more Americans into our current delivery system as we know it today is going to be very frustrating for all of us, members of the Congress, the provider community, and the patients and citizens that we serve.

While we perform medical miracles every day, the current system of medical care, in our opinion, is fragmented, it is uncoordinated, it provides little incentive to focus on prevention, the whole notion of health. We do a wonderful job at taking care of sickness and injury that arrives at our door.

We also have a system where we believe that patients have to kind of fend for themselves. No one seems to be in charge of their care. They kind of move through the system making a lot of their own decisions about where to get their care.

With regard to payment systems, we have payment systems in health care today that reward treatment for each medical encounter, and they are loaded with perverse incentives.

In other words, the more encounters, the more financial return. And we have geographic limitations on access that creates serious problems, so when we talk about access we really need to think more than just about financial access, we need to think about geographic access.

Now, let us take a look at containing costs in general. Most of the proposals that you have been considering that are in the Congress call for arbitrary, top down limits.

By and large, in many instances, command and control regulation of hospitals and doctors, which could be translated into Federal Government micromanagement of very complex organizations. And our experience to date has shown that that does not work very effectively.

And should we go in that direction, we would suggest to you, that there is going to be grave disappointment with the results.

And I share that opinion with you after having spent 20 years working in Maryland as a key player in making the Maryland State Rate Regulatory all-payer system as effective as it has been over a number of years.

In 1976, a stay in a Maryland hospital averaged about 26 percent above the national average. Today, an admission to a Maryland hospital averages about 9 percent below the national average.

So, what we did in Maryland was to have a very effective all-payer rate regulatory system that held down the rate of increase in inflation in hospital costs. And I think hospitals in the State of Maryland ought to be commended for that.

But if you begin to look around at the other indicators of health care costs in the system, what you find is that in Maryland, health insurance costs are pretty much the same as they are in Virginia and in Pennsylvania.

So, what we did is we focused on hospitals and we did not focus on a change in the delivery system. So, we need to go that next step, and that is what I am here to share with you today with regard to the AHA.

The AHA proposes that we reform the organization and delivery of health services in America in a dramatic way. We are really calling for a true reformation.

We suggest that we should create a nationwide system of locally-based community care networks to provide care to a new public program by merging the Medicare and Medicaid program into one, to provide a full range of services into a fixed dollar payment, in essence, a capitated payment rate.

And that fixed payment is the key to changing behavior and providing new kinds of incentives for the provider community. These community care networks are going to focus on collaboration and not the mindless competition we have seen over the past decade.

The networks' community-based collaboration will bring together hospitals, doctors, nursing homes, schools, employers, insurers, and, again, focus on collaboration aimed at affecting health status in our communities, Mr. Chairman.

And the networks will provide a point of entry into a system of coordinated care where someone quarterbacks the care of each of our patients.

And we think that this kind of a system would have the right kind of financial incentives, focusing on prevention, that gets us to deal with the problems that we have today.

We effectively take care of little neonates in our neonatal intensive care units, but why are they there in the first place? Because we believe that no one seems to be in charge of preventive care.

Who is in charge of going out and finding the pregnant teenager to ensure that they get effective pre-natal care? We are suggesting that we want to charge of that. The same with immunization for measles, and all of the rest. We think we have to focus on prevention.

We think that putting these things together, Mr. Chairman, and I will wrap up, will do a good job of reducing the medical arms race that we see across America where everybody tries to have all the latest technology.

We think that putting providers together in an integrated payment system can, in fact, reduce hospital capacity and really realign and infuse technology quite properly.

And the measures of performance for the future should be measures of medical outcome and indicators of health status in the community. Obviously I could go on, Mr. Chairman, to tell you more about this.

But this is our vision of the future, and we think it is time to move there, to move there now, and we have some ideas on how to do that.

The CHAIRMAN. Thank you, Mr. Davidson.

[The prepared statement of Mr. Davidson appears in the appendix.]

The CHAIRMAN. Dr. Keller, if you would proceed, please.

STATEMENT OF GERALD C. KELLER, M.D., VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS, MANDEVILLE, LA

Dr. KELLER. Good afternoon, Mr. Chairman, and members of the committee. I am Gerald Keller. I am vice president of the American Academy of Family Physicians. I am a practicing family physician in Mandeville, LA.

On behalf of our 74,000 active physician and medical student members, I am pleased to discuss with you a topic which we consider of critical national importance: containing our Nation's health care cost.

Three major and interrelated health care challenges face us today. We must guarantee access to necessary health care services for all Americans. We must control health care costs. Thirdly, we must strengthen our health care delivery system to ensure that care is appropriate and of high quality.

Now, none of these goals can be achieved in isolation. Access to health insurance is not meaningful if that insurance is not affordable. Health spending cannot be controlled in the face of the cost-shifting that results when millions of under-insured and uninsured Americans receive uncompensated care.

Earlier this year, by unanimous vote, the academy's board of directors adopted our Rx for Health: The Family Physicians' Access Plan. We feel it offers a comprehensive strategy to address all three of the major health care challenges. And a copy of the entire plan is included with my statement.

In light of the topic of today's hearing, I will focus my remarks on the academy's cost containment strategy outlined in our Rx for Health.

We believe our proposal draws on the strengths of many different reform plans, while protecting the interests of patients, providers, and other players in our health care system.

We call for medical malpractice reform, consolidation of paperwork and administrative expenses, uniform payment methods, and a mechanism for settling and enforcing national limits on the rate of health care spending growth. And all of this, in the context of a generalist oriented health care delivery system.

An important element in our cost containment strategy involves the creation of a national health commission with authority to establish a global budget for aggregate health care spending.

Individual health plans would implement the global spending limits by negotiated managed care type arrangements and payments with providers.

We believe that health plans and providers must have the opportunity to negotiate financing incentives, utilization controls, peer review arrangements, and other case management strategies that make sense in the light of their local needs and practices.

As we all know, Portland, OR is different than Portland, ME, and to work effectively, a cost containment approach must recognize and appreciate the difference.

Our plan builds on the concepts of the Medicare volume performance standard program, with the Nation's goals for spending limits expressed in terms of performance standards.

A performance standard for aggregate health care spending growth would be established, as well as a standard for each major component of health spending, including, for example, hospitals, physician evaluation and management services, surgery, imaging, medical procedures, prescription drugs.

Establishing goals and evaluating performance would take into account not only the cost, but detailed data on why do costs change and how patient access and quality of care may be affected.

Finally, the cost containment strategy outlined in our Rx for Health is premised on a generalist oriented health care delivery system.

The United States is unique in that over 70 percent of our physicians are sub-specialists, while most nations have a physician supply that is 50 percent generalist.

Our over-specialized medical corps is a prime fact to contributing to rising health care costs. It is not equipped to manage care appropriately and tends to prescribe expensive sub-specialty services unnecessarily. Until we address this problem, effective cost containment can be neither legislated, nor negotiated.

Our plan requires enrollees to have a personal physician who is a family physician, a general practitioner, a general internist, or a general pediatrician.

Services rendered by the patient's personal physician would not be subject to a deductible, but would be subject to a 20 percent co-insurance, except for pre-natal, well-baby, and well-child care, and childhood immunizations, which would require no patient cost-sharing.

Services rendered by physicians other than the patient's personal physician, without referral from that personal physician, would be subject to a 20 percent co-insurance penalty.

In our plan we also include suggestions for changing Federal policies to move toward a physician supply in which half of all our physicians are generalists.

Given this committee's jurisdiction, immediate reform should be considered to redirect to the $5 billion in annual Medicare graduate medical education payments which currently incorporate strong though unintentional incentives to train too many sub-specialist residents and not enough generalists.

Family physicians understand that comprehensive health care reform may not be enacted all at once, but change pursued in increments as our Nation struggles for consensus on broader reform.

However, we urge that each step taken be consistent with the comprehensive strategy outlined in our Rx for Health, with an emphasis on promoting a generalist oriented health care delivery system.

The American Academy of Family Physicians looks forward to working with you as, together, we address the challenges of providing universal access to quality care while containing our Nation's health care costs. We thank you for this opportunity to share our views.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. Keller appears in the appendix.]

The CHAIRMAN. Dr. Schenken.

STATEMENT OF JERALD R. SCHENKEN, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, OMAHA, NE, ACCOMPANIED BY CAROL O'BRIEN, J.D., AMERICAN MEDICAL ASSOCIATION

Dr. Schenken. Thank you, Mr. Chairman. I am Jerald Schenken. I am a practicing pathologist in Omaha, NE. We also consult in Omaha, as well as 20 rural communities in western Iowa, Nebraska, and southwest Missouri. I have had the personal experience of seeing almost everything that you have heard yesterday and today, unfortunately.

My daughter is a 28-year-old medical student. Last year, she came home and asked me the following question. She said, dad, let us say you only have enough money to treat one patient, and you have two patients, one of whom smokes. What do you do?

And I have got to tell you, I looked at her, she looked at me, and we went over that. But embodied in that question, I think, is many of the social, economic, moral, ethical and demographic questions which your committee is rightfully struggling to deal with.

But just because problems are insurmountable is no reason not to address them. It is important, however, that we remember that we can easily make things worse. So, it is critical that we keep the reasons for these cost escalations—and, clearly, the rate of increase is not sustainable; everybody agrees with that—clearly in mind as we evaluate the various proposals that we are dealing with.

And they are, and we will go through them briefly: the aging of our population, lifestyle, smoking, eating, lack of exercise, criminal behavior, drugs, trauma, violence, technology which has exploded beyond all of our moral and ethical boundaries, at least in being able to deal with it, general inflation, physician behavior, physician's fees and practice patterns, liability concerns, premiums, defensive medicine, all of those costs, AID's, HIV, third-party payments, and distancing the consumer from the provider. And then public expectations and the visual impact on the public of all of the medical miracles. And, finally, the diversity of our population.

The point is, Mr. Chairman, that everybody is involved in all of these cost-escalating problems, and everybody has got to be involved in the solution. That is the reason that the AMA has developed Health Access America, because it is comprehensive, because

it can be phased in, and because it addresses the behavior of all parties concerned: the physicians, the hospitals, the patients, and the payers, both government and business.

I ask, Mr. Chairman, that the entire statement be put into the record.

The CHAIRMAN. That will be done.

[The prepared statement of Dr. Schenken appears in the appendix.]

Dr. Schenken. But I would like to just list here briefly some of the cost containment issues which we have in Health Access America.

First of all, our practice parameter development and implementation we think is essential. Redeveloping an RVS which will result in improved payment to primary care physicians and rural physicians is on its way; liability reforms, which have been discussed regularly; small insurance market reform; and we are especially talking about such things as community rating, the tax deductibility of premiums for small employers and so forth, and the group purchasing issues.

Administrative, regulatory and billing streamlining for doctors and their offices, and then public education and lifestyle changes.

In addition, we have called on our own physicians currently to not balance-bill patients who have incomes up to 200 percent of the poverty level. And we have been very pleased. It is our estimate that last year our physicians provided almost $700 billion worth of free care.

Now, the limits of the possibilities of cost containment range from a governmentally mandated budget control to one in which the cost is all off-loaded onto the patient and the patient makes the decision. It is clear that both of those ends are unacceptable and unworkable.

So, the question is, where in the middle do we arrive at getting everybody involved and making it workable and acceptable?

The AMA is very anxious to help solve that problem. We have a commitment to the patients, and, of course, we have commitments to the doctors and the young people, like my daughter, who are looking forward to practicing medicine in the future.

Let me just close, in the interest of time, Mr. Chairman, with one plea. And that is, that as you and your colleagues and others look at the physicians of America, please do not ask the physicians to make cost containment decisions at the time they are taking care of an individual patient.

In other words, do not ask them to answer the question my daughter asked me right at the time they have those two patients. Medical care, unfortunately, is too much of an art.

Those decisions are too imprecise at that time. We have to make the cost containment decisions as policy beforehand so that, at the time the doctors take care of the patients, their interest is the patient's interest.

If we create a conflict of interest, if we create pressures to withhold services that are not appropriate, then we will end up having nobody happy; the doctors, the patients, and, eventually the governmental bodies that were involved.

So, Mr. Chairman, I think the AMA recognizes the gravity of the problem and the difficulty you have in dealing with it. We appreciate your personal efforts with your bill, which we have commented on, and, by and large, which we agree with. We look forward to working with you and the committee as best we can to help.

The CHAIRMAN. Thank you. Dr. Keller, the willingness of the Family Physicians group to accept a global budgeting strategy, something supported by organized labor and often other purchasers but not from providers, that is interesting to me.

You do not seem to share the same concern that the AMA has in that regard. Does it not bring about a regulatory approach that physicians often think interferes in their decisions and treatment of their patients?

Dr. KELLER. I think a national health care commission would, in a certain manner, br ng a regulatory approach. We would hope that this commission would set some global budgets for total health care costs, and, within that, develop component parts, whether it be physicians evaluation services, surgical services, imaging, hospital care, et cetera. And maybe even develop global budgets for these individual component parts, though it would not be necessary that all of these parts would live up to these budgets as long as the total aggregate did.

So, we feel, even though we are talking about global budgets, it does leave room for individual insurance companies, public plans to bargain with providers for the best deal that they can give.

Those providers who provide most cost-effective care can, therefore, obtain the best reimbursement for their services as long as the total package stays within a global budget.

The CHAIRMAN. Well, Dr. Schenken, there is a difference of opinion here. Has the AMA ruled out the approach of global budgeting totally, or is that a viable option still?

Dr. Schenken. Well, Mr. Chairman, I suppose that is possible that 1 day we might get to global budgeting. But I think it is clear that the end result of the global budget would be the provision of health care services by doctors and others through hospitals and other places to patients

And with all of the variables over which the medical profession itself and others have no control, it is our opinion that any global budgeting that does not address all of those other things—and they are very difficult—would just lead to more problems than solutions.

I will just give you an example. I lived 25 years in Louisiana and I lived under global medical budgets. This is before Medicare.

The Charity Hospital system was globally budgeted. That was all the money we had. We had the 3,200-bed hospital, the biggest hospital in this Nation under one roof, as far as I know.

Twice while I was there we ran out of money; once in April, I think, and once in May. And both times we had to shut the hospital down except for emergency admissions, shut down the clinics, and just make do on what we had left and re-opened full service on July 1.

They do that in Canada; they partially do that in England. And if you do not address all of these other issues, the appetite of every-

body to provide services and to receive services will go beyond the global budget.

So, I can see the attractiveness of the global budget, but we think it would be a big mistake to do it until we deal with all of the incentives, doctors as well as others. And I have just lived through that and hope not to live through it again.

The CHAIRMAN. But at some point we have to put a budgetary limitation on how much money we spend in this. We crowd out other types of things equally important to our country insofar as the standard of living of our people and opportunities for young people coming along if we continue to put this kind of money into health care on the trend line we are talking about. It is unsustainable. It seems that you have to have some kind of a ceiling put on at some point.

I was listening to Senator Danforth ask the question of the Secretary, which he never answered, about, so, suppose you have a new operation and it costs $1 million and you can keep that patient alive for another 3 months. The family would like that. Those types of things are extraordinary examples. At some point there has to be a ceiling.

Dr. SCHENKEN. Mr. Chairman, as a person and not as a representative of the AMA——

The CHAIRMAN. Now, I would not want to be the doctor making the decision.

Dr. SCHENKEN. Yes. I agree with that as a taxpayer. But I will just tell you, if you look at what has happened in the past, I see on television once a month a discussion of a medical miracle; a bone marrow transplant, or the mother holding the little baby. Who is going to turn that down? And my only view is that we have all get together——

The CHAIRMAN. Look, I have got problems of my own here turning things down. I am going to leave that to you doctors. [Laughter.]

Dr. SCHENKEN. Hold my hand, we will do it together. And I do not mean that in a pejorative way.

The CHAIRMAN. I know.

Dr. SCHENKEN. But unless everybody is in it, then the squeaky parts will escape and I am afraid we will have more trouble than when we started.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, I must begin by complimenting you on your patience. And I am not referring to the last half hour, I am referring to all the time since 9:30 this morning and all day yesterday. It really is sort of a wonder to behold.

I need to pick up where the Chairman left off and some of you representatives have been here through the hours of this hearing. I think you should probably have the same sense that I have that things are changing and they are changing fairly rapidly.

It used to be quite simple to sort of put a line down the middle of this table and say all the folks on one side were for capping things, and the folks on the other side were for changing things. I think it is starting to spread across that line and it is coming this way. He referred to our colleague from Missouri.

You were probably informed—I know I was informed—by people representing the hospitals in this country at how upset folks were when 28 of us went to the floor on the Senate and in sort of a trial vote, voted to cap entitlements.

You watch the Federal budget, just since I have been here, go from 25 percent of our spending in sort of the, if you meet the criteria you get the money category, up to 51 percent now, and then you add interest on top of that for what we are not paying for. We have got a real problem.

So, I understand why the providers of care do not want to see some caps, some budgets, some RBRVS, BPS, or whatever the case may be.

But I trust that you and your members will also understand why people who run companies, people who run labor unions, and people who are responsible for giving direction in government seem to be getting close to saying, let us draw a line at 13 percent, let us draw a line at something.

Now, I have a great deal of difficulty with that because I come from a State in which medical providers are as cost-effective as any in the nation. As far as Medicare is concerned, our doctors and hospitals are paid the least of anyone in the nation.

So, it is really hard to me to continue to vote for caps, or freezes, or across the board anythings, because I know I am penalizing people who are already doing the things that everybody should be doing.

I was at Charity Hospital in New Orleans a couple of months ago, and it is a wonderful institution. It has a terrific, terrific administrator. It is one of the major institutions of the community.

And we sat there with some of the hospital people and I said, when is the last time you closed a hospital in this town, and they had trouble remembering. I come from a community that has closed 31, in all or part. Thirty-one hospitals.

Now, lest you think that gives us automatically lower cost health care, let me say that the survivors are more competitive than they have ever been.

And they are competing at the level of who is going to do the best hearts, or who is going to have the most expensive bone marrow system, or something else.

But there is good news/bad news in this whole system. And you cannot measure a community's commitment to change by how many hospitals it closed, or something like that.

But I think there certainly is consensus on this person's part that unless we change provider and consumer behavior in this country, we do not get the job done. And the issue is how best to do that.

In the last day and a half, we have seen polls up here telling us where to start, because the polls we saw said the consumers think the problem is greed and waste. Providers know better. The providers know everybody is in this.

The providers know that if everybody in America practiced medicine the way the 10 percent best do, we could save big piles of money. And the problem is not the greed of the 90 percent. Maybe 5 percent is greed, or something like that.

The problem is, the other 85 percent do not know what best is in the practice of medicine. External factor says you have got to do this, that, or the other thing or you are going to get sued, or something else.

So, I have come to believe that I have seriously contributed to this problem with DRG's and RBRVS, and say this with Karen sitting in the audience who helped us draft this, the sooner we get rid of the RBRVS, the happier I will be.

And I can say that before we have even started to implement the darn things because all it does is perpetuate a system that pays for services, which means we are going to get a lot more services.

So, I like the notion of some kind of a capitated, risk-adjusted payment rate and I guess we have heard a lot of testimony about how to do that, who to pay that to, I think, in some of the things that Alain Enthoven was talking about. Networks are one that the AHA has talked to us about. I will conclude quickly.

The Chairman of this committee is sort of right in the middle of this, because there is pressure on the one side to do something quickly, and there is pressure on the other side to do nothing, and he is sitting in the middle trying to meet those kinds of demands.

And I think this series of hearings around the subject of cost containment has been very, very helpful. And I think the contribution that each of the major associations has made here to this has been very, very helpful as well.

And the best that I can do as somebody who has been sitting here for 14 years watching the process work is to say that the Chairman is right, something is going to have to be done.

It will not be the knee-jerk, first and easiest thing. It will not be the waste and greed approach because that is not going to solve the problem. Yes, there is some waste; a lot of it. Yes, there is some greed. Yes. But just doing that is not going to change the system. And it also will not be the "do nothing" approach. So, I hope we all come up with an answer to what it is.

The CHAIRMAN. Well, when my friend from Minnesota says something like that, with all the detail, and the study, and the knowledge that he has of the subject, you can see how difficult it is for us to resolve it. But he is a most valuable member of this committee on this subject. I enjoy his counsel, and seek it.

Senator Daschle, would you care to make any comments?

Senator DASCHLE. I have no questions.

The CHAIRMAN. Gentlemen, thank you very much. Yes. Dr. Schenken.

Dr. SCHENKEN. Mr. Chairman, could I respond very briefly?

The CHAIRMAN. Yes, of course. Of course.

Dr. SCHENKEN. In brief response to Senator Durenberger's comments, one of the issues that is poorly understood by some people who deal with the problem is the relationship between the insurance management of risk and the provision of medical care. And what HMO's and managed care plans do is put those things together. They combine the insurance and the care.

As you look at all of these different systems—again, I get to the issue of conflict of interest—just make sure that the risk is not focused on the doctor at the time the care is provided.

And the smaller numbers of people involved, the more likely that is to happen. That is why insurance works, as you know, with big systems. I really do appreciate all that you are doing. This is really a difficult problem. Thank you, sir.

The CHAIRMAN. I have another one. All right, Dr. KELLER.

Dr. KELLER. I would just like to follow up on something that the Senator said. From someone who sees 30–40 patients on an average day—and I think I practice very cost-effective medicine in my family medical practice—we can change physician behavior.

But a great deal of what I do is based upon patient behavior also. And, until we educate our patients in some global manner as to what their expectations are and what their rights are to high-tech technology, we will have a very difficult time in containing costs.

When my patients come in because their child got a bump on the head and insist on having an MRI, which is an $800 test, it becomes very difficult for us.

And we do sit down and talk to them and tell them why we are not ordering the test. But this is one of the things that raises cost of care. We have got to change patient, as well as doctor behavior.

The CHAIRMAN. Thank you. Our next panel will be Mr. Robert Brandon, vice president of Citizen Action, Washington, DC, and Gregory E. Lau, the assistant treasurer of the General Motors Corp. Mr. Brandon, if you would proceed.

STATEMENT OF ROBERT BRANDON, VICE PRESIDENT, CITIZEN ACTION, WASHINGTON, DC

Mr. BRANDON. Thank you, Mr. Chairman. I want to thank you and the members of the committee for holding these hearings. And I want to focus on three important goals as we take a look at cost containment strategies in health care.

First of all, efficiency. Cost containment strategies have to focus on achieving efficiency gains in the areas most responsible for excessive spending: administrative cost, excess capacity, high fees and prices, and unnecessary services.

But we also, when we take a look at trying to bring costs down to make health care more affordable to more of our population, we cannot lose sight of the fact that we need to, in fact, expand access. And if bringing costs down also reduces access, we have defeated at least part of our purpose of trying to control costs.

So, it is very important in constraining health care spending that we not just look at measures to bring costs down, because then you would have less of a debate over things like explicit rationing in an Oregon approach; or the implicit rationing as proposed by managed care advocates; or the elimination of State-mandated benefits and other laws as proposed by small group insurance reform advocates; or cost-sharing requirements as proposed by many; or the exclusion of necessary benefits from basic benefits packages under various pay-or-play approaches.

By following a cost containment strategy achieved through efficiency gains, you no longer are just focusing on reducing costs. You are, in fact, going to be able to deal with these non-cost goals.

But you also, then, thirdly, have to look at equity issues—in particular at the progressivity of financing mechanisms, the comprehensiveness and quality of services available to Americans. Be-

cause, again, we both are dealing with how people are paying for the health care they get and what kind of health care they receive.

The question of equity is particularly serious in the health care approaches that fail to substantially reduce overall cost, but, instead, simply shift cost from one group to another.

In the current small market reform debate, for example, we believe that the approach is to ameliorate the cost problems of some small businesses whose employees are at high risk for higher health care costs by shifting the cost over to the rest of the small business community.

In fact, Ken Sematore, representing Blue Cross and Blue Shield of Ohio, has testified that the effect of small group reform would be to raise the premium rates of some small firms by as much as 20 percent and to increase premiums for all small firms by about 10 percent across the board.

These reforms also allow massive cost-shifting to small business employees through increased premium costs, higher deductibles and co-payments, and reductions of benefits through the elimination of State mandates.

So, we have to keep those three goals in mind when we take a look at what can be done effectively in cost containment. I would propose to take a look at the following: primarily, efficiency, cutting costs through the most efficient means because that means we are leaving the most amount of dollars for the care of people.

When you take a look at efficiency, first and foremost, we would support the approach taken by Senator Wellstone and others, the single-payer approach.

And the General Accounting Office estimates that $67 billion in administrative costs could be saved from the paperwork and the economies of scale obtained through the single-payer mechanism and used to expand access.

Other plans that rely on private insurance are relying on and resting on delivery of insurance services in the least efficient sector of the economy.

A recent study by Citizens Fund, Citizen Action's research affiliate, called Premiums Without Benefits, concludes that the commercial insurance sector is spending 37.2 cents for administration, marketing, and overhead to provide $1 worth of health care benefits to policyholders.

And that is 40 times less efficient than the system that they have in Canada, and 18 times more efficient than our own Medicare system.

When you wrap in all private insurance together, HCFA estimates that about 16 cents for every dollar of benefits provided is overhead, again, compared to 2 cents or so for Medicare, or less than a penny for the Canadian model.

The Congressional Budget Office also pointed out the larger administrative savings potential of a single-payer system as opposed to an all-payer mechanism, because we can eliminate the other overhead costs.

For example, those costs include doctors and hospitals trying to comply with paperwork burdens, employers trying to decide who is going to receive what kind of insurance under their employment system, employees coming in and out of the system, et cetera.

When you take a look at an additional savings, we have talked a lot about global budgets, fee schedules and expenditure caps. The experiences of the members of this committee, I think, with the Medicare program, would underscore the cost savings potential of the prospective payments for hospitals and physicians.

But it is important that those reimbursement rates be standardized. It is also important that, to the extent that those rates are established through negotiation, that the negotiator has proper authority.

We see in Germany, for example, individual sickness funds negotiating on the basis of nationally-established relative point value scales. But, depending on the market power of the sickness fund, some do very well and some do not do as well, ranging from 8 percent to 16 percent of payroll that their premiums account for.

I would maintain that a single-payer system would provide a much more effective way of bringing those costs down under a negotiated fee schedule or negotiated hospital budgets.

And let me say, further, that the expenditure ceilings must be enforceable and as inclusive as possible. The German experience, again, with targets versus enforceable caps, is instructive.

From 1977 through 1985, physician care expenditure targets resulted in a 7-percent annual growth rate. Between 1985 and 1987, when the binding spending cap was in operation, the growth rate increase was only 2 percent.

Obviously, there are other important reforms that I allude to in my testimony: resource allocation, practice guidelines and technology assessment, prevention and wellness, alternative providers; all of those things will work better in a single-payer and comprehensive systemic environment.

Let me just mention very quickly two areas that we have heard a lot about in terms of controlling costs: managed care and cost sharing. There are, of course, examples where managed care delivery systems have controlled cost increases while maintaining high consumer satisfaction.

But, overall, the evidence suggests that the premium rate increases for managed care do not differ substantially from increases of conventional plans.

In fact, the HIAA survey of employers from 1989 to 1991 indicates that in managed care plans, average increases were 15 percent, compared with 17 percent for conventional plans.

In general, managed care strategies center on several cost controlling approaches: first, negotiating payment terms of selected providers. There, the problem is, managed care can do that, but it is simply shifting costs to somebody else.

Secondly, by limiting and influencing, or influencing the choice of providers, we are, in fact, rationing care.

There are complaints all of the time from patients in HMO's who find that they are limited to the availability of specialists, wait for a long time to get the needed care that they require. I mention a few of them in my testimony.

And then there is also just the issue of stretching out schedules, waits for initial appointments, delays in obtaining care. All are an attempt to reduce overall costs, but, in fact, what we are doing is also limiting access.

Senator RIEGLE. Can I just ask you to finish in about 30 seconds? I do not want to hurry you, but I do want to get to our next witness and have time for questions.

Mr. BRANDON. Yes, I will. Third, the utilization review of practice patterns is an important cost control strategy.

Increasingly, though, the same insurance companies that are overruling physician's clinical decisions and denying claims payments to conventional insurance policyholders are doing so in a managed care setting, as they increasingly own more and more of the PPO and HMO market.

Finally, on cost sharing, I would say that we are concerned that cost sharing is not an effective way to reduce utilization without, in fact, limiting needed care for those who cannot afford it otherwise.

And if you try to take care of people who cannot afford the cost share, you are adding enormous complexity and cost to the system, an estimated $18 billion, according to some studies.

The Rand study that has been cited a lot on cost sharing found little difference of utilization once you made contact with the delivery system. So, there, we are concerned that cost sharing is, in fact, going to discourage not only inappropriate care, but appropriate care alike.

Senator RIEGLE. I am going to have to ask you if you can end at that point.

Mr. BRANDON. Yes, I will.

Senator RIEGLE. Because we want to hear Mr. Lau, and we do have some questions for you.

Mr. BRANDON. Yes.

Senator RIEGLE. Thank you very much.

[The prepared statement of Mr. Brandon appears in the appendix.]

Senator RIEGLE. Mr. Lau.

STATEMENT OF GREGORY E. LAU, ASSISTANT TREASURER, GENERAL MOTORS CORP., NEW YORK, NY

Mr. LAU. Good afternoon, Mr. Chairman, and members of the committee. My name is Greg Lau and I am assistant treasurer for the General Motors Corp., with responsibilities which include health care.

Today's hearing focuses on an issue of crucial importance to General Motors and to the international competitiveness of U.S. business. That is, the need to curb the alarming rate of growth in health care costs in this country. At GM, health care expenses are growing faster than any other labor, capital, or material cost incurred in the production of a motor vehicle. And these growing outlays for health care erode our ability to fund other pressing corporate objectives.

By way of background, GM is the largest private purchaser of health care in the United States, spending almost $3.4 billion in 1991, or $929 per vehicle, and providing coverage to about 1.8 million persons. Not only are our absolute expenditures for health care enormous, but they also place us at a serious disadvantage relative to the Japanese transplants. We have lower costs because they have younger work forces and a virtual absence of retirees. The spi-

raling increase in health care costs places a special burden on mature industries like ours that have extensive responsibilities to our employees and our retirees.

My objective today is to share some of GM's experiences in the hope of illustrating the kinds of cost containment actions that may be required. GM's health care costs on a per person basis continue to rise at an average rate of about 11 to 12 percent a year. Although lower than the 15–16 percent average rates for all manufacturers, it is still significantly higher than the rates of increase in the consumer and the producer price indices. Clearly, a more aggressive and comprehensive approach to health care cost containment is needed.

In the mid-1980's, GM undertook a series of initiatives to exert more control on its rising health care costs. Two actions that proved instrumental in reducing GM's administrative and overhead costs for health care were the decisions to move to a self-funded basis and to establish a nationwide claims and eligibility system. The standardization of the claims process also provides the capability to perform on-line edits of payments that helps us prevent fraud and duplication. However, trimming administrative costs is not a sufficient strategy to control the rising costs of our health care. Rather, the key to controlling health care costs lies in managing the use of services– without such controls, long-run cost containment is unlikely.

Perhaps the most significant of GM's cost containment initiatives was the re-design of our benefit plans to expand managed care. By design, managed care programs are intended to control the use of services by providing incentives for both providers and consumers to reduce unnecessary or ineffective services. We added a pre-determination process to our traditional fee-for-service program and offered both PPO's Preferred Provider Organization and Health Maintenance Organizations (HMO's) as coverage alternatives. Also, salaried employees who select to remain with the traditional program are now subject to cost sharing requirements that also reduce GM's cost and utilization.

Our experience with these programs has been mixed. In large part, the effectiveness of PPO's depend on their ability to identify and exclude providers from the panel who do not provide quality care in the most cost-effective fashion. However, we have found that highly selective panels are difficult to achieve, in part, because of provider-relations issues, employee concerns about provider selection, and the reluctance of program administrators to address the objective aggressively.

In some cases, these issues have even given impetus to State anti-managed care legislative proposals, which we strongly oppose. Managed care can work. One of our most notable success stories, both in terms of quality and cost, involves our substance abuse coverage.

GM, together with its unions, conducted pilot studies that identified serious concerns about the cost and quality of care being received by our members. In response, we implemented a national pre-determination program, appointed local case managers, and established a closed panel of providers who meet basic quality and cost effectiveness criterion. Subsequently, through close monitoring

of data, we instituted further changes in coverage that, in effect, placed sanctions on our employees who did not seek care when needed, or complete the planned course of treatment.

This integrated approach to managed care with incentives for individuals and providers worked. The quality of substance abuse treatment improved significantly and costs decreased dramatically. Further, the acceptance of these changes by our covered population was positive. Building upon this success, we are now treating our mental health coverage in the same way.

From our experience, we believe it is critical to build managed care principles into the design of any health care program. Careful attention needs to be given to basic benefit design to prevent unnecessary utilization and avoid coverage of marginal value, including the over-utilization of technology. Appropriate cost sharing should be an integral component of any plan because of its proven effectiveness in promoting judicious consumption of health care services. Clinically sound guidelines for the provision and use of services should be established in advance, along with objective criteria for selection of high-quality, cost-effective service providers. In addition, to support managed care efforts, more work needs to be done to establish effective outcomes measures and practice guidelines.

In summary, GM's experience with managed care suggests specific controls on service use and service delivery are necessary for effective cost containment if the United States is to have an affordable health care delivery system. As a nation, we must decide what services we are willing to pay for and the most effective manner to deliver those services.

GM believes health care reforms are in order if the United States is to meet the health care needs of its people and improve its competitiveness in global markets. If mature manufacturing companies are to succeed, it is essential that actions which truly contain costs and improve our competitive position are taken. Towards this end, GM also supports efforts such as the incremental measures proposed by this committee's Chairman, that move us in the direction of these goals and add to our understanding of this very complex issue. Thank you.

Senator RIEGLE. Thank you very much, both of you.

[The prepared statement of Mr. Lau appears in the appendix.]

Senator RIEGLE. Mr. Lau, let me ask you. You have cited here, and these are really very compelling numbers, and I want to emphasize them. General Motors is the largest private purchaser of health care in the United States. You spend about $3.4 billion every year; did in 1991. Is that right?

Mr. LAU. That is right, sir. It was up——

Senator RIEGLE. And the cost is running at about $929 per vehicle produced. Is that correct?

Mr. LAU. That is correct.

Senator RIEGLE. Do you have comparable numbers, by the way, in terms of direct cost of production through the respective companies of what that health cost per car might be, or health cost per vehicle might be, say, in Japan or Germany?

Mr. LAU. Yes. Based on available data.

Senator RIEGLE. It is a small fraction. Yes. What is that number?

Mr. LAU. It is under $100 for the transplants, compared to our $929.

Senator RIEGLE. That is for the Japanese companies here in the United States.

Mr. LAU. That is correct, sir.

Senator RIEGLE. It is less than $100, versus the $929 that you are experiencing.

Mr. LAU. Correct.

Senator RIEGLE. And that is partly due to a younger work force and no retirees to have to provide health insurance for, I assume.

Mr. LAU. Yes. It is for both those reasons. Others include difference is productivity and vertical integration versus General Motors.

Senator RIEGLE. Now, when you take offshore Japanese companies, any data as to what those health care costs are per car of cars built in Japan? The red cost that——

Mr. LAU. No. I can try to find that. I do not have that with me. We basically look at a total cost basis when we try to compare ourselves.

Senator RIEGLE. Yes. But they have a national health system in Japan, so most of the health care cost would not come in as a direct cost of production, would it?

Mr. LAU. I would agree with that.

Senator RIEGLE. So, we have an enormous differential. Now, another way of saying this is that there is no company in America that will gain more if we can control health care costs than will General Motors. Is that not a fair conclusion to reach?

Mr. LAU. From those figures, yes, sir.

Senator RIEGLE. Yes. So, you have the most to gain of any single company. And I would say, just given my own knowledge of the company and some of the problems that we have been facing in the industry in rough numbers, I think General Motors has lost something on the order of 11 percentage points of market share over the last few years, so there has been tremendous pressure on the company. It is well-known.

Mr. LAU. It is, sir.

Senator RIEGLE. Large operating losses, and so forth. If we can find a way to do something on health care costs, not only would General Motors be the largest private sector beneficiary of that, but it would mean an enormous amount of saving, would it not, if we could get these numbers down?

Mr. LAU. It would depend on the exact details of how we did it.

Senator RIEGLE. Right.

Mr. LAU. We are very concerned about the tax rates, about whether or not major manufacturers would be disproportionately burdened—i.e., those large employers that already have these large costs. We would have to look at the details, but on a theoretical basis, yes, I would agree.

Senator RIEGLE. Now, let me ask you, then. In the GM policy statement which you have submitted, you note the concern of the company over the health care system's "excessive expenditures on paperwork and red tape."

And the paper advocates regulation of provider charges, presumably to eliminate cost shifting, which is, of course, a major problem.

Now, the spokesman here for Citizen Action advocates a single-payer system to address precisely the problems of administrative cost and cost shifting.

The GM position paper states that GM is "open to consideration of a broad range of strategies which would require reliance on either the private or public sectors, or both."

Mr. LAU. That is correct sir.

Senator RIEGLE. My question to you is: is GM open to consideration of a single-payer system as a means to control health care expenditures?

Mr. LAU. As the first step, I would say that we would again be concerned about the details of exactly how single-payer system was written in the legislation.

As we have indicated in the reform statement that I attached to my testimony, there are four principles that we would try to judge to see whether such a system meets them.

With regard to a global budgeting proposal or a single-payer system like the Canadian model, we believe if the plan does not attack utilization—if it does not attack the demand quotient—that we will continue to see pressure brought on everyone to raise the total in the budget.

We would be happy to work with you on something like that. We have tried to lay down in that attachment what principles we think a proposal like that should include—whether it is the Canadian system, whether it is the West German system, or an improved American system.

Senator RIEGLE. Can you give me an estimate of how much of this $929 in health care costs per vehicle at General Motors would be the estimated cost that comes from just cost shifting, or from your estimates of what the administrative overhead is? Because we have got this system where——

Mr. LAU. Well, our administrative overhead is at right around 8 to 9 percent. And we have been working hard on that the last 4 or 5 years with our carriers, with our new claims eligibility system.

Senator RIEGLE. What about the cost shifting, what is your estimate on that?

Mr. LAU. I do not have an estimate. I would have to get to my experts and come back to you on that. It is very subjective.

Senator RIEGLE. But would you not be inclined to believe that that is a pretty substantial number?

Mr. LAU. Absolutely.

Senator RIEGLE. I mean, the cost shifting is really a major part of the burden you are carrying, is it not?

Mr. LAU. Absolutely, Senator. Both in the uncompensated care and the under-compensated care, at all the hospitals. That is why we are putting a major effort into the managed care area in our negotiations with providers to try to halt some of that shift, but we have it, in the Medicare and Medicaid programs, tremendously toward us.

Senator RIEGLE. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Mr. Lau, in reading your statement I was not able to find the degree to which you think your success with the approach you are using now to contain costs has been effective. I do not see any figures.

Managed care has been referred to throughout the last 2 days as a meaningful way with which to reduce costs, but very few people are ever able to say to this extent.

There are always a number of conditions associated with the degree to which success has been achieved. Could you give us any indication as to how successfully you have been able to utilize managed care?

Mr. LAU. Well, let me take the one example that was in the testimony and talk to you broadly about it. The one example that we have spent a lot of time on collectively with all of the GM constituencies, including our unions, is the substance abuse program.

And, now we have extended that to mental health. We have seen substantial quality improvement, substantial reduction in costs in that program over the last 4 years.

And what we did there was we took our previous panels, which numbered probably about 2,100 providers, and we brought it down to about 1,500 providers. So, we had about a 30 percent reduction in the panels, and we reduced our costs over the last 4 years by 20 percent.

Now, that would go up on the ledger as any good example of how we met all of the model managed care principles. We have not been as successful at all on the PPO's and with our HMO experience. We have been working very hard.

As I indicated in my statement, we have been troubled by the PPO's and the lack of provider selections, and on tremendous increases in out-patient expenses.

So, our record is mixed on that. We have a full effort on right now to see how we can improve our system, both on improving quality and having a more cost-effective system. But looking at our experience, we have had some problems. But in the last 4 years it has turned against us in many of those PPO and HMO plans that our employees participate in.

Senator DASCHLE. So, your answer as to the overall effect of implementing managed care thus far is what?

Mr. LAU. On an actual basis where we have focused on it, we have been very successful. Where we have not had a closed panel, we have not been successful.

Managed care, to be successful, Senator, needs to have some of those principles that I identified, and one of them would be a closed panel. We have to improve our system on that.

And right now we are looking at our PPO's, and our HMO's—we have about 37 percent of our population in those, and when we take a look, because we can with our data, on age and sex so we know precisely the nature of our employee population in managed care; we have set very aggressive targets on where we think costs ought to be versus our traditional program. And our PPO's/HMO's have not met those targets.

Senator DASCHLE. So, you are not satisfied with the 11–12 percent increase in cost that you have acquired in spite of your best efforts with managed care. Is that what you are saying?

Mr. LAU. To date, yes. We intend to improve that. We have an all-out effort, but we can not do it by ourselves.

Senator DASCHLE. Mr. Brandon, you mentioned the German plan. Throughout the discussions on comprehensive care, many

people referred to the German plan as a fairly appropriate example of how 1,400 independent insurance companies can work in unison that appear to be fairly successful in Germany in containing costs and providing universal access.

How is it that sickness funds in Germany appear to be working, and that the German Government appears, through the utilization of sickness funds, to control costs in spite of the tremendous number of participants in what is, at least on the surface, a multi-payer approach?

Mr. BRANDON. The main thing I would say is they do not rely on private insurance companies. The sickness funds, people need to understand, are non-profit funds, number one.

Number two, you do not have the adverse risk selection that you would have in this country or that you do have with people offering policies to certain groups on the marketing side, or people jumping from policies to policies on the purchasing side.

When you are in a sickness fund in Germany, that is it. You are there for life. You move around in your employment, but you stay with the one sickness fund.

So, it is like comparing apples and oranges. You certainly cannot translate that model to a system that relies on 1,500 private insurers that are competing with each other and spending an enormous amount of overhead trying to gain market share, trying to gain customers.

Secondly, there is a problem, as I mentioned in my testimony, about the relative success at negotiating down prices. Larger sickness funds with greater market power have been much more successful than others; the variation is quite substantial from fund to fund and the German Government, I think, is trying to work on that.

But, again, it demonstrates a little bit like with the managed care issue altogether in terms of market power and bringing costs down. You can do it if you can negotiate rate reductions, but if it is simply going to get shifted over to somebody else, we as a country have not solved our cost problem.

I would dare say that in GM's situation, a substantial amount of their cost reductions through their managed care program, I assume, is because they have been able to obtain rate discounts because they are such a large purchaser. That helps mitigate some of their problems, but does not solve the overall cost problems.

Obviously, where we want to look to managed care, I think, is in the reduction of inappropriate care. And I think there it can play an important role, but only in an overall system that brings costs down directly through expenditure caps, global budgets, and fee schedules.

Senator DASCHLE. Well, I am out of time, but I thank both of you. Thank you, Mr. Chairman.

Senator RIEGLE. Thank you, Senator Daschle. We have been joined by Senator Wellstone today, who has a keen interest in this area. Senator Wellstone, did you have some questions you wanted to pose?

Senator WELLSTONE. Thank you, Mr. Chairman. Let me, first of all, just say to Mr. Brandon, I do not need to be convinced of the importance of single-payers, especially on the way in which we

should spend money differently; less on administration and more in the delivery of services.

But let me take Mr. Lau's point that I think was an interesting one, which is the question of how you see the single-payer kind of bill I have introduced dealing with the potential problem of over-utilization.

Quite to the contrary about all of the problems that we hear about rationing in Canada, I think probably a fairer critique is just the opposite. People do have care that is available and accessible, but the issue is one of maybe over-utilization. Could you speak a little bit about that?

Mr. BRANDON. I think the Canadian system does not seem to encounter the over-utilization problem. The real question here, I think, is are we going to see increased utilization? Yes. Is it because we have denied appropriate care up to now? I think the answer also is yes.

But, specifically, we need to deal with the utilization question in health care planning, and we can do that in a lot of different ways.

In your bill I know you do it in a lot of different ways with planning agencies and budgets, and the Canadians try to do that. You have separate capital budgets for hospitals, you have ways of dealing with periodicity schedules for physician treatments.

There is a whole panoply of things that we want to be doing on utilization, whatever system we have. But the real point here is, let us do it within a system that, number one, is most efficient to begin with, in terms of our overall costs of delivery in that system and, number two, in a system that inherently, because it is system-wide, allows us a much better handle on planning.

So that many of the areas we have talked about just work better. That is what I tried to say in my testimony. They work better under a single-payer system rather than people out there like GM trying to do a job of managing health care because they are fairly large, but they are still not as large as the Federal Government or the State.

Senator RIEGLE. And being swamped by health increases that they cannot handle.

Mr. BRANDON. That is right.

Senator WELLSTONE. Let me ask two other quick questions, because I want to ask one of Mr. Lau, if that is all right. One more for you, Mr. Brandon. There is a focus, of course, on covering those without any health insurance, and, then, of course, there are those that are under-insured.

Do you see from the administrative efficiency of a single-payer that from that savings alone we would have the resources to cover the uninsured? I mean, can you say that unequivocally?

Mr. BRANDON. Well, I do not think you can say it unequivocally, but what you can say is that it would move toward covering everybody. And an important piece of our health care explosion, it seems to me, is that people who are not receiving care are winding up costing the system much more when they finally do show up in an emergency room or do not get treated until much later.

So, prevention is going to work much better when you have coverage in the first instance and people do not worry about financial barriers to care. So that this is an area that you have got to be

careful about saving money, and being penny wise and pound foolish. So, I guess that would be my response.

Senator WELLSTONE. So, the point is two-fold, as I understand it, Mr. Chairman. Number one, there are the administrative efficiencies to single-payer, and you and other people can talk about CBO and CBO reports, and all the rest.

Your second point is that when care is available, if you have a package of benefits that is especially tilted toward preventive health care, that is another place where you not only do the right, humane thing, but you can effect significant cost savings.

Mr. BRANDON. That is right. I think it is a mistake to just focus on administrative savings.

Senator WELLSTONE. All right.

Mr. BRANDON. They are substantial in a single-payer system, and they are substantial not only on the payer side, but on the provide-side as well.

But there are also many other components of that system that will bring costs down, including increased prevention, people not putting off decisions about going to the doctor, and better resource allocation through global budgeting and other kinds of health planning strategies.

Senator WELLSTONE. Mr. Chairman, I want to ask just one final question.

Senator RIEGLE. Please, go ahead.

Senator WELLSTONE. Of course, we are all proud of things that we work on, and I just want to amplify the point that Mr. Brandon made which is above and beyond the whole question of administrative efficiency.

I think all too often we do not focus enough on the importance of what universal health care coverage really means with a package of benefits that is really tilted toward preventive health care and building accountability into the system. I mean, there are many ways that we can attack this issue of cost control.

I am really going to be interested in your answer to this question, Mr. Lau. I read about the struggle of the company; certainly the Chairman has talked a lot about this as a major economic issue in our country in labor management relations.

If you had to sort of prioritize where you feel ambivalent, let us say, about moving toward single-payer, since that is what we are talking about for the moment, how would you rank that?

I mean, where do you put your misgivings and what are the concerns that you have, and if you could kind of list them for me it would be helpful.

Mr. LAU. All right.

Senator WELLSTONE. Try and be kind, now, all right? [Laughter.]

Mr. LAU. I think that our experience so far in the cost increases that were mentioned this morning for just the public programs of Medicare and Medicaid, I think we have a lot of opportunity there just to demonstrate whether or not some of our cost containment ideas could work, and we have not seen that. Price controls in those programs simply come over to us and they do nothing for utilization control.

We certainly have seen some significant increases in costs in the Canadian system, albeit from a lower base. Their system took 30

years to get where it is today; the German system maybe 100 years to get to where it is today.

And I think that there are certain cultural things that help bring their costs down. I think it is very difficult to put those systems in total into our system.

We have tried to enumerate there some of the principles where we could, in fact, discuss areas of a large public-type ownership of the health care system.

But, in many ways, the incremental approach of an enhanced public/private partnership should be tested—I think that we have a lot of knowledge to gain in outcomes research, in clinical diagnoses, and clinical practice standards. We see that, because of the breadth of General Motors, certain procedures vary substantially across the country, both as to number of tests, how the procedures are performed, the number of days in the hospital, and the resulting cost.

I think those are areas that we know something about, we are learning a lot more about, and that we could make some suggestions.

I think some of the witnesses today indicated that the government needs to enhance more of the State outcomes research, the local planning outcomes research. There is a lot of knowledge there that I think we can use prior to jumping in to a single-payer.

But, back to your question, Senator, on the managed care, I think the best managed care system that we could design and put in, we still need your help in attacking a lot of these other areas. So, that is why I get back to the public/private enhancement.

Senator WELLSTONE. Right. Well, I thank you for your comment. I look forward to working with the Chairman, and you, and others.

And I think part of what we have here already is a public/private partnership, because one thing that is important about single-payer and variations thereof and the kind of bill that we all work on together, however we come together, we are talking about single-source financing. But, of course, it is not government-run clinics or government-run hospitals.

Mr. LAU. I understand that.

Senator WELLSTONE. It is not bureaucratized, it is consumer choice within a pluralistic framework. And I think we have to keep it that way in our country.

Mr. LAU. Yes, I agree. And we would be concerned about maintaining that in a system that we come up with.

Senator WELLSTONE. Thank you, sir.

Senator RIEGLE. Thank you, Senator Wellstone. Let me just say in that area, that four of us here have developed a plan that we think in a sense takes the incremental approach, public/private partnership, with our bill, S. 1227.

Now, there are four very serious co-sponsors of this: myself, Senator Mitchell, Senator Rockefeller, Senator Kennedy.

In this bill, in many ways, it seems to me sort of takes a position along the lines of what I hear you saying. I want you to look at it in a very serious way.

Mr. LAU. We would be happy to.

Senator RIEGLE. Because I think the private sector which is being badly damaged by the cost pressures of the current system

suddenly loses its voice when there are practical alternatives on the table to look at and to, perhaps, help us either implement or move from. We are not locked in stone on this.

Mr. LAU. All right.

Senator RIEGLE. But what happens is, is that even though you are being bludgeoned by these costs that you can not by yourself control, there is this enormous kind of loss of vitality and voice when it comes to actually dealing with practical alternatives that are being put on the table, in part, to help this company and other companies like it.

And people around the country are not now under private health insurance plans. But, going to Mr. Brandon's point, as you well understand as well, there is no good argument in practical economic terms or in moral terms for letting somebody get sick and then treating them in a high cost way when their illness or medical problem is very severe when we could spend far less early in the game and avoid that.

Mr. LAU. Absolutely.

Senator RIEGLE. I mean, that is just crazy economics, and it is crazy human policy. So, take a look at this and see if General Motors cannot find its voice on this issue, or on this particular approach, or ones like it.

Or let us know if there is a part of it here that you think is solid and that you can be supportive of, or other parts that you think ought to be changed.

Mr. LAU. Yes, we could, sir. All right.

Senator RIEGLE. We are open on that. I am open on that. But I think if all we do is continue in a circular debate, you are going to be eating more cost increases that you cannot handle and it is just going to be bad news down the line all the way around.

Mr. Brandon, I appreciate what you have said here today. You have seen our plan. I know you advocate the single-payer plan. As we have discussed that here and as we have worked to try to build enough critical mass to be able to move a package and get out of this gridlock, I think it is fair to say that it is hard to collect enough of a center of political gravity to be able to sort of drive this whole process off dead center and get something significant done.

I know what you would like to see, if you could have everything that you think we ought to have here. I am not sure we can get there at this particular time, quite apart from how persuasive your arguments might be, or some other arguments might be.

I think we can make material improvements in the existing system, and I think we can capture some of the major gains, including getting coverage out to people and getting some cost control mechanisms in place, and getting a regime in place that starts to discipline this system. And where we go from there, I think time would tell.

I am concerned about the fact that we are sort of getting immobilized right at the beginning, so the pressures are such that we make no real change, it just sort of stays up in the air as a debating issue.

The President comes in just before the election and says he is going to have a few bits and pieces of a plan; they are still not here. I would like you to take a look at this, as well. I know you

have. I would like to see what parts of it you might be able to be for.

Mr. BRANDON. Let me make two comments, Senator, because I know you have spent a lot of time developing that plan. One, is that from a practical political point of view, the atmosphere here in Washington is very different than the atmosphere out around the country, and I know you have travelled, obviously, back to your own State and probably elsewhere as well.

The approach that you have taken, I think, does not do enough at this point to promise the people with insurance who are watching it crumble and are worried about whether or not it is going to be there tomorrow, next week, next year——

Senator RIEGLE. Right.

Mr. BRANDON [continuing]. Assuring them that the solution you are proposing is going to help them. They can see that it might help somebody else over there, but it is going to be hard to mobilize a lot of that middle American support for the people who are insured who are watching it crumble under this approach.

Senator RIEGLE. Because you feel we need a cost control mechanism that is much stronger?

Mr. BRANDON. Because they do not see in their own lives how it is going to help their insurance plan become more affordable, because it will help someone else get insurance, and then there is a vague notion that there will be some limits on it.

Secondly, the cost controls. If we are going to have serious cost controls, we have got to take on some very powerful interests who are going to have to give up some income in this area, or at least give up the growth in income in the future.

In order to do that, you have to mobilize a great amount of public support. And I think it is very difficult, again, to mobilize that support from people that do not see their circumstance improving dramatically in this instance. So, that is our problem with the politics of your approach. And then on the substance——

Senator RIEGLE. All right. Can I just take you on that one for a minute?

Mr. BRANDON. Yes.

Senator RIEGLE. And I appreciate what you are saying. I am very interested in your view on this. I would appreciate in that area any practical suggestions that you can offer us, short of saying start over again, to take that area of this package, and I am prepared, speaking for myself, to go through a re-thinking, a re-engineering of what has to be done there to assure us that we are going to get the practical results we need.

And, obviously if you have that, then you can go out and attempt to marshal the public support. I quite agree with you that if it is a hope that is not very compelling to people, that that does not get us out of this circular debate that continues to go on.

So, I would ask you to give me whatever specific suggestions you might have in that area that would do that, if you can do that without sort of contradicting your own view that there——

Mr. BRANDON. I would be happy to do that.

[The following information was subsequently received for the record:]

RESPONSE BY MR. BRANDON TO A QUESTION FROM SENATOR RIEGLE

While Citizen Action continues to support single-payer reform as outlined in S. 2320, we are happy to respond to the request to recommend improvements under a "pay-or-play" structure. Here are several such recommendations.

First, we believe that coverage must be expanded through additional benefits. The minimum benefit package in S. 1227 does not cover many necessary medical services and items, including items such as prescription drugs, ambulance service, physical therapy which are often provided under employer-based plans. In addition, some preventive services (such as colorectal exams, adult checkups) should be included in conjunction with periodicity schedules. Finally, we support inclusion of long-term care services. It has been extremely difficult to get support from our members who have benefit packages more comprehensive than the minimum package or from our members on Medicare who would receive no assistance in obtaining benefits not now covered by Medicare.

We would recommend expanding the benefit package to include some or all of the above-mentioned benefits under the minimum benefit requirements as well as Medicare. We would also recommend inclusion of a maintenance of effort requirement to prevent businesses which are now providing additional benefits from dropping coverage to the level specified in the minimum benefits package.

Second, we would recommend elimination of the cost-sharing requirements in S. 1227. Citizen Action is opposed to point of service cost-sharing for the following key reasons. First, cost-sharing is a financial obstacle to care which may result in decreased utilization but does not differentiate between unnecessary and necessary utilization. Second, the majority of utilization is provider-determined and not consumer-determined. Third, cost-sharing is regressive. The out-of-pocket limits set in the bill do not solve these problems since they do not solve the problem of copayments and deductibles nor do they set limits progressively. (An out-of-pocket limit *for covered services* for a family of three earning $22,000 does not equate to an out-of-pocket limit for a family of three earning $220,000).

There are two other items in this area which are of particular concern to us. First, there is the provision allowing employers to require that part-time and less-than-full time employees pay more than 20% of the premium. Under this provision, the very employers who are less likely to have and less able to afford health insurance are penalized. (This is apart from the incentives for employers to hire other than full-time workers).

Second, the alternative wage-related deductibles and out-of-pocket limits are troubling to us in that they would increase cost-sharing burdens. Remembering that the out-of-pocket limits do not include premium costs, consider what happens to a family of four earning $40,000. If their employer chooses the alternative out-of-pocket limit (10% of $40,000 or $4,000) and the family paid 20% of a $4,000/year premium ($800), they would be liable for $4,800 or 12% of their income (we assume from the language that this is gross, and not net, income). This does not even take into account their health care costs for non-covered services or their HI contribution.

In terms of the cost-sharing requirements related to managed care, we are concern about the lack of cost-sharing limits on managed care (preferred providers) in general and the limit of 200% of the "normal cost-sharing" in the case of an employer who only offers an managed care plan. Again, we see these cost-sharing requirements as presenting financial obstacles to care and limiting freedom of choice. There are many instances in which a consumer may need to go outside of the network—long waits for appointments or treatment within the network, PPO physicians not taking on new patients, lack of specialization, geographic limitations for highly-specialized treatment—that are not recognized in this provision.

While we recommend an outright elimination of point of service cost-sharing, there would be some steps which could be taken to mitigate this problem. cost-sharing could be eliminated for preventive services and services prescribed by a physician (i.e., what is the point of a 20% copayment for a coronary bypass advised by a physician?). The wage-based alternative and deductibles could be eliminated.

Third, S. 1227 effects insurance practices as they apply to policies sold to small businesses. While small businesses have received the most attention in terms of insurance company abuses, they are not the most vulnerable insurance policy purchasers (individual policies are subject to greater underwriting and higher costs) nor are they the only businesses confronting with those practices.

We would recommend that any program which relies on the private insurance industry (a reliance which we oppose) applies reforms to all insurance policies across the board. Moreover, the insurance industry should be made subject to federal antitrust law and the *Pilot Life* case should be legislatively repealed in order to protect policyholders.

Fourth, while under the version of S. 1227 reported by the committee on Labor and Human Resources, the Board is required to set expenditure, quality and access goals, each of those requirements is conditioned with the phrase "to the maximum extent practicable." Particularly since those qualifying phrases refer to the setting of the goals rather than specific means of achieving those goals, this language provides an out for any presidentially-appointed commission to ignore these key recommendations.

We recommend striking the phrase "to the maximum extent practicable" wherever it occurs.

Fifth, because a pay-or-play structure does not guarantee universal coverage, S. 1227 imposes penalties on persons who cannot certify that they have insurance coverage—either through the public program or through private means. Particularly without knowing the cost of public coverage, this penalty could not only be punitive but counterproductive. For example, the cost of public coverage could be unaffordable (either because an individual is ineligible for a subsidy or the subsidy is insufficient). In that instance, is it really productive to deny that person a Pell grant, unemployment insurance, or a FmHA/FHA mortgage? Under this provision, an individual or family with high health care costs related to medical needs not covered under the required benefit package—i.e., prescription drugs or substance abuse/mental health services beyond those provided in the bill—could be confronted with a choice of either paying for insurance which meets the minimum standards in order to obtain federal benefits or purchasing the health services that they actually need.

Because of the possible inequities in this section, we believe that it should be deleted.

Sixth, we do not support the preemption of state managed care and utilization review laws. The former area is of concern to us because so many of our members complain about long waits, failure to provide specialized care, and other managed network problems. The latter area is of concern to us as many of our members complain about arbitrary insurance company claims denials which override their physicians' advice. (Earlier in the bill, insurance companies in life-threatening instances are given 24 hours after the information they request is presented to them to make a determination, with a subsequent 5-day review process. In each case, the threatened life may have ended. There are no limits in non-life-threatening cases.)

We recommend that states be allowed to set pro-consumer regulations on both managed care and utilization review.

Finally, Citizen Action believes that any pay-or-play system should allow individuals and businesses to buy into the public plan at a rate no higher than the actual cost. We are concerned over provisions which appear to be protecting private insurance companies from having to compete with a publicly-run entity, provisions which require that rates be set in a fashion to maintain the "balance" between private and public coverage. Such a requirement not only reduces possible cost savings but creates the potential for unfairness by allowing some to take advantage of lower costs why denying others the same opportunity.

We recommend this provision be eliminated.

Mr. BRANDON. And the other point I was trying to make is that it is difficult to take on the cost control mechanisms as efficiently as you can under single-payer.

You do not have as much money to spend on the public program. The result is, you are still back in a two-tier system where the public program is inferior to the private program and you set up the situation where either you have to decide in order to deal with it, something Senator Rockefeller talked about earlier, a tension to keep everybody status quo. And our experience is that that means for the millions of Americans who are watching their insurance crumble, they have to stick with the private-based insurance system. They do not like that.

Senator RIEGLE. Yes.

Mr. BRANDON. And if it means for the millions who do not have insurance or who wind up getting dumped into a public program, it is not as good as they perceive theirs is now. That is not a solution, either.

So, I think you have a dilemma here. If you put a program together where both plans are equally good and you have an all-payer system with a serious cost-containment like the way the Germans approach it, then I think you have got a more manageable system.

If you try to craft together what you have got now and build on private insurance without bringing out all of those inefficiencies, I think you have a real problem on your hands. But I would be happy to talk to you more about that.

Senator RIEGLE. Well, it is difficult either way you go. I mean, it is something that just as a practical structural engineering decision, leaving out sort of all of the politics and the cross plays on that, it is a difficult choice either way you go. And the problem now, I think, is getting out of the situation that we are now in.

And it is, in some respects, self-reinforcing, as bad as it gets, and as much as you would think that would cause finally some kind of a break-through to move off that to something that is a substantial improvement.

We are not seeing that happen. Part of that is an absence of leadership at the top of our government, and part of it are these internal quandaries as to how far do you go.

Can you take and on the margin adjust our employer-based insurance system and have a two-tier system and have a good, solid, basic benefit program in place that is kept to high standards, it is there, and you may very well have something available on whatever basis as an add-on to that in your system. I mean, that would be, in my view, a major improvement over where we are today.

I do not know if you were here earlier, but I was citing the case of a single working mother in Detroit who has a 6-year-old son that she cannot afford to insure, and is under no insurance system whatsoever in our country this day, and there are 300,000 of those type of children in Michigan today. I think if the public even knew that fact and could express itself in some way to say, all right, that we want taken care of, there is the will in the country to take care of it.

Mr. BRANDON. I think there are some examples of this, though, in the States where, in an effort to not take on the whole issue, there have been bare bones policies and other approaches and small market reform tried. Number one, very few people offer the policies; very few people buy them.

Senator RIEGLE. Right.

Mr. BRANDON. But it does not do any good to get somebody in the door to a doctor's office if they have a $500 or $250 family deductible.

Senator RIEGLE. Right.

Mr. BRANDON. They can not do it.

Senator RIEGLE. Yes.

Mr. BRANDON. They cannot spend the money to walk in the door.

Senator RIEGLE. Yes.

Mr. BRANDON. And that is the problem with scaled back benefits. So, what I am concerned about is we do not go through a process where we develop an answer to the plan, and then we find out it exacerbates the problem, it does not solve the problem.

And that is my concern with the small market reform. I own a small business in Massachusetts. When my father died, I unfortunately inherited it. It is not doing very well.

But I understand the costs of small businesses in terms of health care. And these small market reform plans are not going to help me provide health insurance to the 12 employees when I employ; in fact, I suspect, will only make matters worse.

Senator RIEGLE. Yes.

Mr. BRANDON. So, I think that is a short-sighted answer. We will be back here again, and GM will be back here again in 2 years with their costs even higher if we do not do something comprehensive. And I know you were talking about wanting to do something comprehensive.

Senator RIEGLE. Yes. In that area, I have some of the same concerns you do. I see small businesses in Michigan right now that are dropping coverage, even for the owner, let alone the employees of the business, because they just cannot afford to maintain it. That is why we have tried to draft a comprehensive plan here.

In our view of AmeriCare, the plan that people would have access to and come in if they were not in an employer-based insurance plan, I do not envision that as something that is cut-rate and does not get the job done.

I mean, I envision that as something that would be solid, not only in terms of its access, but also in terms of the kind of care that it would offer.

The quandary I see is that I think it is possible in today's climate to do something like this. I think something like this would be a whole lot better than what we have. Now, you may agree or disagree.

What I am not able to see right now is how we take, given everything that is out there, and jump over this kind of a comprehensive plan which I think moves off our existing system in some new directions.

I think if something like this or something tailored off this concept is not where we go next, it is probably going to take us much longer and much more back pressure and much more agony to finally, if and when we do, sort of jump to some plan that is more like what we have seen in other countries, which, as you say, have had several decades to develop it; in some cases 100 years to develop it.

We are very late in dealing with this problem in our country. I mean, we have had a period of time when the focus has essentially been on foreign policy and a lot of sort of economic nonsense during the 1980's and we were not paying attention to these things. Now we have got a terrible job of catch up.

And, as the system is sort of in gridlock, trauma centers closing down, hospitals under tremendous pressure, firms that offer insurance cannot maintain it, whether they are big ones like GM, that are struggling, or small ones like the one that you inherited in your family, or ones I see in Michigan.

And we continue to talk it back and forth and talk it around, but we are not moving off where we are to something that is a major incremental step. And I am not talking about minor, small incremental steps.

Mr. BRANDON. Right.

Senator RIEGLE. We just tried that. I am for doing some of those, but not as a substitute for something that is much more basic. It is interesting that Senator Kennedy—I cannot speak for him, although he is one of the four co-sponsors of this bill—at an earlier point in time, I think it is fair to say, was advocating a plan more like what you are here advocating today.

He, over time, has moved off that, I think, in part—again, I am not trying to speak for him, but this is my belief—because of the feeling that in order to get off where we are today to something that is substantially better, we have got to go to something that is more along the lines of this kind of engineering design.

So, again, what I want to say to you is I would like your thoughts as to how the parts of this that give you the greatest heartburn within the general concept that we are putting out, would be addressed. I mean, the things that are in here that strike you wrong may well be wrong and may well need to change. And I am open to changing them.

But I am not sure that we ought to get ourselves pinned in a polarity which is either more of what we have got now with a little tiny bit of tinkering around the edges, or something that is so sweeping that it is really beyond practical reach. And that is where I am coming from.

Mr. BRANDON. I just want to underscore, Senator, what I said before. We have 3 million members around all parts of the country, and it is very difficult to convince people in Cobb County, GA that this plan works for them when they have got insurance, they are watching it erode, they see the co-payments and deductibles go up.

Senator RIEGLE. Right.

Mr. BRANDON. It is much easier to talk to them about a universal system. They begin to understand that. I think in order to have a system that works in terms of delivering the goods, in terms of bringing costs down and making it universal, you have got to overcome an awful lot in terms of the interest groups arrayed that do not want to make the change. And, in order to get the public behind you, I think this may not do it.

So, I would be happy to talk about the substantive differences which we may have. For example, the lack of prescription drug coverage in here.

I cite an example in my testimony of a family who had HMO coverage, they thought they were taken care of, and their daughter was born with a rare liver disease and they are now $130,000 in the hole in order to take care of that child.

She is going to need $3,000–$4,000 of prescription drug medicine for the rest of her life, if she is lucky enough to be able to afford a transplant. She would not be taken care of in that proposal, under a bare bones proposal without prescription drug coverage.

So, those are the concerns that I have on the subject. I would be happy to talk to you about it some more.

Mr. LAU. Senator, we would be happy to look at it, too. As I indicated, I think the movement toward a sweeping proposal well beyond yours, when we survey people and we ask them what is wrong with the current health care system or their co-pays, or deductibles, or insurance programs, we never tell them the bad

news about some of these national systems, like exactly what would be covered, what would not be. It is a two-way street in many of these things.

And what we are trying to decide as a nation is how much we do want to spend. I think that is very difficult for the individuals wherever they are in this country. Those type of questions, and those inconveniences and lack of choices that may result to them, are not being explained to them.

So, something has to change; we agree with you. But to go to a wholly new system, we would want to back off on that. So, we will take a hard look at your bill.

Senator RIEGLE. Well, I think it is important. And I will just finish up by saying that I do not know how much more—I think I probably know General Motors as well as anybody in the Congress knows General Motors. I grew up in Flint and spent part of my whole life there, and I certainly pay very keen attention to what is going on in this company.

Mr. LAU. Yes. We appreciate it.

Senator RIEGLE. And what plants are staying open, what ones are closing, how we are doing, and so forth. The $929 of estimated health care costs per vehicle is a crushing load.

You can close a lot of plants and you can get rid of a lot of tiers of management, and what have you. I do not think you can shrink the company fast enough to offset the rate at which those health care costs are increasing per car.

I do not think the competition is going to ease up one iota in terms of what I see them doing. I think these health care costs are an urgent dynamic in the future of General Motors.

Mr. LAU. We would agree with you.

Senator RIEGLE. And, so, one way or another we are going to have to reform this system, I think, quite quickly and quite substantially so that the cost shifting element, which is a major part of the problem for you, the administrative overhead, not just in your own shop, but that is buried into all of the other costs that come around through the system—by your own definition, there is no company in America that has more to gain or lose by some serious reforms in health care than General Motors does.

And, so, I want to act. I want to get something done. And there are some other people around here that want to get something done. There are some people around here that do not want to do anything because it is a Hobson's choice.

I think you lose if we do not get something done. I do not think that is a viable alternative for General Motors, or Ford, or Chrysler, or any other company in America any longer. I think we have to do something.

And, so, I would really like your help in figuring out what we actually can do to change this. So, take a look at this. I would like to hear your reactions to it in detail and we will take it up with my other co-sponsors. Thank you both.

Mr. LAU. Thank you.

Mr. BRANDON. Thank you.

Senator RIEGLE. Thank everyone for their presence today. The committee stands in recess.

[Whereupon, the hearing was adjourned at 3:32 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF DREW E. ALTMAN

Mr. Chairman, Members of the Committee, I am Drew Altman, the President of the Henry J. Kaiser Family Foundation, located in Menlo Park, California. Thank you for inviting me to appear before you today to discuss public attitudes toward health care and reform of our health care system. Before I turn to these subjects, let me say a brief word about the foundation.

The Kaiser Family Foundation is one of the nation's largest private foundations devoted exclusively to health. Established in 1948 by industrialist Henry J. Kaiser and his wife Bess, the foundation now has assets of approximately $400 million. The foundation is not associated with Kaiser hospitals or with the Kaiser Permanente Medical Care Program. At present, we devote our philanthropic expenditures ($23 million last year) to those efforts we believe will help make government more responsive to the health needs of the American people, help improve the health of low-income and minority groups, develop a more equitable and effective health care system in South Africa, and promote innovation in health care in our home state of California.

The foundation is fortunate to have an extremely knowledgeable and distinguished Board of Trustees. Among them are two of your congressional colleagues: former Senator Dan Evans (R-WA.) and former Congresswoman Barbara Jordan (D-TX). I might add that Senator Evans currently chairs our Board.

Given our interest in helping government better respond to this country's growing health care problems, we aim to work cooperatively, constructively, and in a nonpartisan manner with federal and state officials laboring in this vineyard. I have attached to my statement, for your information, a brief description of some of the foundation's major projects and studies which may be of interest to you and your staff. Please feel free to contact us for updates, findings, or additional information.

This Committee is beginning the arduous task of considering and formulating major legislation to reform our nation's health care system. It is an unenviable, but desperately important job. You are all familiar with the litany of grim statistics that attend discussions of health care in America, so I won't repeat them here. But these points do bear repeating: We are, collectively, paying an alarming proportion (14 percent) of our GNP for health care and, over the last decade, our annual health-related expenditures increased at roughly two to three times the rate of inflation. Yet despite these staggering expenditures, we have between 35 and 40 million Americans with no health insurance at all. We have millions of others who are underinsured or are fearful of losing what coverage they have because they or their employers can no longer afford to pay skyrocketing premiums. We have no systematic long-term-care insurance; we have no catastrophic care insurance, despite this Committee's best efforts. We have a Medicare Trust Fund that is nearing bankruptcy and a Medicaid program that is literally gobbling up state budgets. We have impoverished inner cities and rural regions of the country where many residents are Medicaid eligible, but there are no or far too few doctors, clinics, and hospitals to serve them. Even where there are sufficient providers, too many of them now refuse to serve beneficiaries of public programs because Medicaid and even Medicare do not offer high enough rates of reimbursement. And even though we spend more per capita on health care than any other nation in the world, no one will argue that we are purchasing better health outcomes for our population.

Clearly, we have compelling reasons for reforming our health care delivery and financing system. Experts know this, even though they may disagree about what to

do. Policymakers know this, witness these hearings. Voting-age adults in the U.S. know it too, though they, like the experts, are not yet certain about what to do.

As you know, there have been numerous polls and surveys conducted in recent months attempting to identify those issues of major concern to the public. Last year, it was noteworthy when health care first appeared as an identifiable issue blip on the public's radar screen. Since that time, a number of polls have shown health care to be a great concern; our own survey shows that anxiety about health care, particularly its cost, ranks second only to more general worries about the economy.

I would like to summarize some of the key findings of the Kaiser Family Foundation and the Commonwealth Fund survey. We commissioned Louis Harris and Associates to conduct a survey of the public's experiences with and concerns about health care, and their attitudes toward reform of the health care system. The survey was taken between January 31 and February 24, 1992, and questioned a national, random sample of 2,000 voting-age adults. The appendix to my statement includes the key questions, as asked, and a breakdown of some of the answers given by income and political party affiliation. We can also provide breakdowns by age, gender, ethnicity, health status, and insurance status.

Our survey confirmed that there is widespread public fear about the rising costs of health insurance and the erosion of health care benefits. Substantial numbers of respondents reported serious problems paying for care.

The more startling findings, however, are the unambiguous desire for major-reform and the clarion call for government—specifically federal government—leadership in that effort. TABLE 1 shows that over half (57%) of the respondents believe the country's health care system is so flawed that it requires major change (38%) or a whole different system (19%). About one third of those surveyed (35%) think only minor changes are needed. These numbers hold up fairly consistently across party lines: 50% of Republicans, 59% of Independents, and 61% of Democrats call for major reform or a different system. Across party lines, the majority prefer "major change" to a "different system."

TABLE 2 shows that when asked who should have the primary role in providing health insurance to all Americans and in controlling health costs, the resounding answer, across party lines, is the government (60%). The private sector came in a poor second (34%). Again, a majority of all respondents (52% of Republicans, 62% of Independents, and 69% of Democrats) want government to take the lead.

TABLE 3 probes the "government" answer further. When asked to state a preference between the federal government or state governments, respondents forcefully answered, by a two to one margin, that the federal government should take the lead in changing the health care system (62%). State governments got the nod from only 30%. Only 3% thought health reform should be a shared federal-state responsibility. It is striking, again, to note the parity across party lines (59% of Republicans, 62% of Independents, and 64% of Democrats) want the federal government to take the lead in reforming health care.

TABLES 4–6 demonstrate that those surveyed want the government to take direct action in curbing health care costs. When asked whether the government should set the rates that insurers can charge for health care premiums, fully three-quarters agree it should (straight across party lines). When asked whether the government should set the rates that doctors and hospitals can charge patients, over 70% agree it should (fairly consistently across party lines). And when asked whether government should set the prices for prescription drugs, 73% agree it should (again, pretty much across party lines). These were the single strongest findings in our survey.

TABLE 7 shows that over half (55%) of those surveyed said they would be interested in a health plan which limits choice of doctors and hospitals in return for real savings in out-of-pocket health care costs. How do we reconcile the strong support for both managed care and direct government intervention to limit provider costs? We suspect that, taken together, these answers reveal that what the public wants most is relief from rapidly inflating health care costs. The clearest illustration of this point comes from our November 5–6, 1991, post-election poll of voters in Pennsylvania. TABLE 8 shows that whether they supported Wofford or Thornburgh, voters were near universal in naming cost as the "biggest problem with health care." No other problem got significant mention.

From these seven questions, we can fairly conclude that people want major reform of the health care system, they want the government to take the lead in this effort and, specifically, they want the federal government to take charge. Further, they want direct government intervention to control costs, but are also willing to support alternative approaches to cost control.

Our findings on the next three questions I want to highlight for you are a good deal murkier. Given that health care access and cost are weighing heavily on Ameri-

cans' minds, and that the White House and both parties in congress have set forward different approaches for addressing these issues, we asked respondents to express a preference for one of three "national health plans,": play-or-pay, single-payor, or a tax-credit approach. TABLE 9 shows the answers and the actual descriptions of the three plans provided to respondents. What the data clearly show is that those surveyed split, almost equally, among these three major options for reform (33% opted for play-for-pay, 30% for single payor, and 27% for the President's tax credit plan). Once again, these numbers show remarkable consistency across party lines. What the data do *not* explain is what causes this ambivalence. Perhaps the respondents do not really understand the implications of each of the proposals and their resulting confusion leads to an apparent three-way tie. Perhaps they think they understand and genuinely divide over how to best get from here to there, as the "experts" have done for all these years. We really don't know and can only speculate. However, it is interesting to note that even when presented with three possibly confusing alternatives, only 2% responded by saying that "things should be left as they are."

Given our earlier poll in Pennsylvania, we were interested in knowing whether health reform could be a winning political issue for presidential and congressional candidates as it proved to be for Harris Wofford. Our national survey shows that health reform clearly has the potential to be a big political issue in national elections, but that no party or candidate has yet connected with the public on a health reform plan.

TABLES 10 and 11 show that health care ranked as the second most important issue (the economy was first, by a two-to-one margin) on voters' minds when they vote for president, senators, and representatives. TABLE 12 shows that health fades in importance when voters consider statewide candidates, such as governors and state legislators.

TABLE 13 shows that those surveyed don't yet make the association between the three competing options for reform (play-or-pay, single-payor, and tax credits) and the political parties pushing them. When asked if they see "any real difference between the health care reform proposals of the Republicans and Democrats," over two-thirds (68%) saw "no real difference." This high figure held constant across party lines (69% of Republicans, 70% of Independents, and 67% of Democrats saw no difference).

TABLE 14 shows that when asked if they could identify any political leader or candidate whose health care reform proposals they supported, fully 80% could identify no such leader or candidate. Again, this number holds across party lines (80% of Republicans, 77% of Independents, and 82% of Democrats). Of course, this answer could mean that respondents do know what these various candidates have been saying about health care reform and just flat out disagree with them. More likely, however, is that no candidate has yet succeeded in capturing anyone's attention on this potentially important election-year issue.

I hasten to point out that these "snapshot-in-time" answers, particularly the three-way split on competing reform options, the failure to differentiate between the political parties, and the absolute failure of any recent candidate to leave his imprimatur on health care, could change drastically as the parties nominate their presidential candidates and the election-year debate heats up. I say "could" because, as we all know, health care reform could be displaced as an issue by other breaking events. If the recovery stalls, if there is sudden unrest in Russia or the middle east, health care reform may move, temporarily, to a back burner.

The key word here is "temporarily." Our survey, like others, shows that worries about health care are pervasive and growing. Consider these powerful findings:

CONCERN OVER HEALTH INSURANCE FOUND THROUGHOUT THE POPULATION

Eighty-two percent of all Americans report a significant health insurance worry. The biggest concerns:

- Sixty-one percent of those surveyed worry that health insurance will become so expensive that they will no longer be able to afford it.
- One of every two respondents *with insurance* worries that benefits under their current health plan will be cut back substantially.
- Fifty percent of those surveyed worry that they will have to pay very expensive medical bills not covered by their insurance. By contrast, in this recession, only 33 percent worry that they or their spouse will lose their job.

MILLIONS OF AMERICANS ARE HAVING PROBLEMS OBTAINING MEDICAL CARE

- Approximately 23 million Americans needed medical care but did not get it in the last 12 months. Approximately 18 million could not get medical care for financial reasons.
- Last year, 54 million people postponed care they thought they needed for financial reasons.
- About 7 million Americans were denied health insurance because of a prior medical condition.
- Nearly 22 million Americans said they themselves, or someone else in their family, or both, had been refused health care during the last year because they didn't have insurance or couldn't pay.

Perhaps, most important, we are seeing a change in a litmus test measure of satisfaction with health care. Historically, the public has favored "reforming" the nation's health care system in the abstract, but has been satisfied with their own individual health care arrangements. This now appears to be changing. TABLE 15 of our survey shows that in the last five years, the number of people dissatisfied with their health care services has doubled, from 13% in 1987 to 26% in 1992. Such a dramatic swing in the public's mood would suggest that Americans may truly be ready to accept significant reform of their health care system.

Mr. Chairman, it is tragic when citizens of the richest country in the world are denied adequate health care. We have known for years that poor and low-income Americans are often refused appropriate, timely care. And, not too surprising, our survey confirms that low-income people and those without any insurance have trouble getting care.

What was surprising was the extent to which higher-income people, those we would call middle-class, and those with insurance, are experiencing difficulty obtaining and/or paying for medical care. There can be no doubt that health care access and cost have become middle-class, pocketbook issues.

The cautionary lesson from our public opinion survey is this: Health care may or may not remain one of the top issues on voters' minds this election year. But it is here to stay as a major issue. People are increasingly unhappy with their own health care arrangements. Regardless of income and insurance status, significant numbers of people are being refused care or postponing necessary care because of cost. The numbers of unhappy and angry voters will grow as health care costs continue to skyrocket out of control. In the not too distant future, government officials—particularly those at the federal level—will be perceived as part of the problem or as part of the solution.

ATTACHMENT—CURRENT FOUNDATION PROJECTS RELATED TO FEDERAL AND STATE HEALTH CARE POLICY

THE KAISER COMMISSION ON THE FUTURE OF MEDICAID

This fifteen-member panel is studying short- and long-term solutions to the myriad problems of the Medicaid program. The Foundation has committed $5 million to fund the commission over the next five years. The commission is chaired by James R. Tallon, New York State Assembly Majority Leader, and includes as members former Senator Charles Mathias (R–MD), former Senator Henry Bellmon (R–OK), and former Governor Richard Riley (D–SC).

EXPANDING THE USE OF MANAGED CARE IN MEDICAID

The Foundation is supporting a demonstration of Medicaid managed care quality assurance standards being developed in partnership with the Health Care Financing Administration (HCFA) and the National Academy of State Health Policy. Funds will support the demonstration in two states, as well as administration of the project by the National Academy of State Health Policy, Portland, Maine. HCFA will help select the demonstration sites and disseminate the lessons learned about the practicality, cost, and effectiveness of the quality assurance standards. An outside evaluation of the demonstration will be funded separately.

OPTIONS FOR A CAP ON NATIONAL HEALTH CARE SPENDING

At the Foundation's initiative, Brandeis University is studying whether a spending cap on the rate of increase in U.S. health expenditures is viable, and if so, how to put it into practice. Researchers will evaluate such issues as the impact of a cap on patients and providers, what types of health services should be included under a cap, and how it could be administered.

ANALYZING PROPOSALS FOR NATIONAL HEALTH CARE REFORM

With Foundation support, the National Academy of Social Insurance will develop a framework for analyzing proposals for national health care reform. The academy will assess all major health reform plans, including how each plan proposes to finance reform, how costly it will be to administer, the amount of red tape it will generate, and whether plans for reimbursement are practical.

FORUMS ON THE CHANGING NATURE OF FEDERAL HEALTH POLICYMAKING

The Foundation is supporting George Washington University, Washington, D.C. to develop a series of National Health Policy Forums that will examine the interaction between federal policy and state programs and how federal policy encourages or impedes innovation and effective program management. Topics may include the role of waivers in health policy, and the impact of the budget process on health policy reform.

ANALYZING LONG-TERM HEALTH CARE REFORM OPTIONS

The Brookings Institution will analyze and compare major approaches to reform, including those that were introduced during the last Congress. Among them are proposals to: liberalize Medicaid eligibility standards, make community-based care more accessible, provide limited or comprehensive nursing home coverage, and encourage coordination between public coverage and private insurance plans.

A STUDY OF RESIDENTIAL CARE FACILITIES AND THEIR RESIDENTS

The Foundation is funding the Institute for Health and Aging, University of California at San Francisco, to conduct the first statewide survey and analysis of residential care facilities (also called board and care homes) and how well residents' needs are being met. These facilities provide room, board, and supervision to those elderly who are no longer able to live independently in their own homes, but who are not in need of the 24-hour medical attention provided by skilled nursing homes. As our population ages, demand for these facilities will grow, but little is known about residents' needs or the quality of care they now receive. This study seeks to provide a factual basis for policy directions on residential care. The Institute will identify problems and propose options for change.

A DISCUSSION SERIES FOR HOUSE SUBCOMMITTEE MEMBERS, SENIOR STAFF

With Foundation support, the American Enterprise Institute for Public Policy Research, Washington, D.C. is hosting a discussion series on issues under the jurisdiction of the Human Resources Subcommittee of the House Ways and Means Committee. The series will be developed in collaboration with the Brookings Institution.

STATE PUBLIC HEALTH LEADERSHIP RECRUITMENT CENTER

The Center, administered by the National Governors Association, is the first national effort to match qualified public health managers, especially minority candidates, with senior state government positions in health policy and management.

A NEW CENTER ON STATE SERVICES FOR DEPENDENT POPULATIONS

The Foundation is funding Brandeis University/Bigel Institute, Waltham, Massachusetts and the National Academy for State Health Policy in Portland, Maine to help states find solutions to the special needs of the elderly, mentally ill, and disabled populations that are heavily dependent on state services. The new national organization—the Center on State Services for Dependent Populations—will examine the choices states make between institutional and community services. The center will evaluate programs and compile comparative information to show states what is happening elsewhere. It will also convene policymakers to share experiences and develop new policy options.

SCHOOL-BASED HEALTH SERVICES PROGRAM IN CALIFORNIA

The Foundation, in partnership with the State of California and other non-profit funders, is launching a statewide school-based health services program for children. The program will begin in 100 low-income school districts and eventually expand to all low-income school districts in the state. School clinics will offer on-site comprehensive health and social services to poor children and their families. The program will enable all schools to be reimbursed for health services through the Medicaid program.

AN EVALUATION OF PUBLICLY-FUNDED FAMILY PLANNING SERVICES

The Foundation's aim is to determine whether the family planning needs of poor women are being met and, if not, recommend changes. The Urban Institute will evaluate the availability and accessibility of such services, describe funding arrangements, examine the role of Title X of the Public Health Service Act (the federal program that provides such services), and develop recommendations for the future of family planning.

FAMILY PLANNING SERVICES FOR SUBSTANCE-ABUSING WOMEN

The Foundation is funding the Pierce Country Alliance, Tacoma, Washington to provide and evaluate the delivery of family planning and obstetrical services to substance-abusing women. A full range of family planning services, including the implantable contraceptive Norplant, will be offered on a voluntary basis to women in a variety of criminal justice and social service programs. The study will follow the women's choices of contraceptives, pregnancy outcomes, substance abuse recidivism, criminal justice outcomes, and the costs of treatment.

DO THE DISADVANTAGED RECEIVE THE MEDICAL PROCEDURES THEY NEED?

In order to learn whether a routine, but expensive medical procedure is withheld from patients because of their income, race, or insurance status, the Foundation is supporting the UCLA School of Medicine to conduct a study of coronary revascularization procedures (coronary artery bypass graft surgery or angioplasty) performed on patients with critical coronary artery disease to prevent heart attacks and control chest pain. Investigators will examine records in several Los Angeles area hospitals to determine whether these factors influenced whether a patient who needed such an operation got one.

TABLE 1

Question -- Which of the following best describes how you feel about the country's health care system?

	TOTAL	REP	DEM	IND
Works as well as expected	5%	8%	3%	4%
Works fairly well/ Minor changes needed	35%	40%	33%	35%
Works badly/ Major changes needed	38%	38%	39%	37%
Works so badly/ Different system needed	19%	12%	22%	22%
Not sure/Refused	3%	2%	3%	2%

Source: Kaiser/Commonwealth Health Insurance Survey

TABLE 2

Question -- Who should have the primary role in providing health insurance to all Americans and controlling health costs?

	TOTAL	REP	DEM	IND
Government	60%	52%	65%	62%
Private sector	34%	43%	26%	35%
Not sure/Refused	6%	5%	6%	4%

Source: Kaiser/Commonwealth Health Insurance Survey*

TABLE 3

Question -- If it's a choice between the federal government or the state governments, which do you think should take the lead in changing the health care system?

	TOTAL	REP	DEM	IND
Federal	62%	59%	64%	62%
State	30%	33%	28%	29%
Both Federal & State	3%	3%	3%	3%
Neither	1%	1%	1%	2%
Not sure/Refused	4%	3%	4%	4%

Source: Kaiser/Commonwealth Health Insurance Survey

* Party affiliation totals are based on self-identification, not actual registration.

TABLE 4

Question -- Should the government set the rates that insurers can charge for health premiums?

	TOTAL	REP	DEM	IND
Agree strongly/ Agree somewhat	75%	74%	78%	75%
Disagree somewhat/ Disagree strongly	22%	25%	20%	23%
Not sure/Refused	3%	2%	2%	2%

Source: Kaiser/Commonwealth Health [illegible]nce Survey

TABLE 5

Question -- Should the government set the rates that doctors and hospitals charge patients?

	TOTAL	REP	DEM	IND
Agree strongly/ Agree somewhat	71%	69%	74%	74%
Disagree somewhat/ Disagree strongly	27%	30%	25%	25%
Not sure/Refused	2%	1%	2%	2%

Source: Kaiser/Commonwealth Health Insurance Survey

TABLE 6

Question -- Should the government set the prices for prescription drugs?

	TOTAL	REP	DEM	IND
Agree strongly/ Agree somewhat	73%	69%	77%	74%
Disagree somewhat/ Disagree strongly	25%	30%	21%	23%
Not sure/Refused	2%	1%	2%	3%

Source: Kaiser/Commonwealth Health Insurance Survey

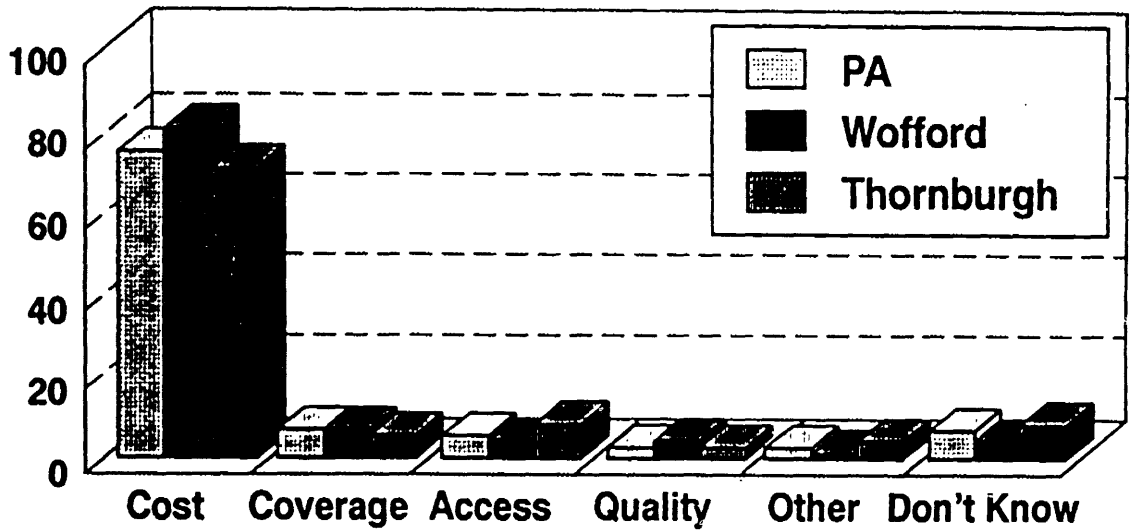
TABLE 7

Question -- If you were offered a different health plan which limited your and your family's choice of doctors and hospitals in return for real savings in your out-of-pocket costs, how interested would you be in changing to this plan?

		INSURANCE		
	TOTAL	Private	Medicaid	None
Very interested/ Somewhat interested	55%	53%	48%	63%
Not very interested/ Not at all interested	43%	45%	45%	33%
Not sure/Refused	3%	2%	7%	5%

Source: Kaiser/Commonwealth Health Insurance Survey

THE KAISER FAMILY FOUNDATION/HARVARD PENNSYLVANIA POST-ELECTION POLL



In your opinion, what do you think is the biggest problem with health care for you and your family?

November 5-6, 1991

TABLE 9

Question -- Which of the following ways of financing health care would you favor?

OPTIONS FOR REFORM	TOTAL	REP	DEM	IND
Play-or-Pay	33%	30%	36%	33%
Single-Payor	30%	27%	33%	30%
Tax credit plan	27%	32%	21%	27%
Leave things the way they are	2%	2%	0	2%
Not sure/Refused	8%	8%	9%	8%

Source: Kaiser/Commonwealth Health Insurance Survey

(Actual questions asked) A national health plan in which businesses are required to either offer private health insurance for their employees or contribute to a government program that would cover them. Those who are unemployed or work part-time would be enrolled in the same government program, financed by taxpayers. To control costs, government would set the fees charged by doctors and hospitals. **(Play-or-Pay)**

A national health plan financed by taxpayers in which all Americans would get their insurance from a single government plan. To control costs, government would set the fees charged by doctors and hospitals. **(Single-Payor)**

A national plan which would offer low- and moderate-income uninsured Americans an income tax refund to help purchase private health insurance. Those who are not insured would have access to care through tax supported public health clinics. To control costs, financial incentives would encourage enrolling in less costly health care plans. **(Tax Credit Plan)**

TABLE 10

Question -- The next presidential election will be in November 1992. What two issues do you think will be of most importance to you in determining who you will support?

ISSUE	TOTAL	REP	DEM	IND
The economy	50%	55%	46%	51%
Health care	25%	24%	27%	24%
Taxes	11%	12%	10%	11%
Jobs	8%	6%	10%	8%
Education	7%	8%	8%	7%
Foreign policy/Aid	5%	7%	3%	6%
Abortion	4%	5%	3%	4%

(total responses exceed 100% because respondents were asked to name two issues)

Source: Kaiser/Commonwealth Health Insurance Survey

TABLE 11

Question -- What two issues will be of most importance to you in deciding which Congressman or Senator to support?

ISSUE	TOTAL	REP	DEM	IND
The economy	34%	38%	32%	36%
Health care	19%	17%	23%	19%
Taxes	12%	16%	10%	13%
Education	11%	11%	12%	11%
Jobs	6%	5%	8%	5%

Source: Kaiser/Commonwealth Health Insurance Survey

TABLE 12

Question -- What two issues will be of most importance to you in deciding who you will support for Governor or State Representative?

ISSUE	TOTAL	REP	DEM	IND
The economy	29%	33%	27%	30%
Education	21%	24%	22%	19%
Taxes	20%	26%	15%	21%
Health care	11%	8%	14%	12%
Jobs	8%	6%	10%	9%

Source: Kaiser/Commonwealth Health Insurance Survey

TABLE 13

Question -- Do you see any real difference between the health care reform proposals of the Republicans and the Democrats, or not?

	TOTAL	REP	DEM	IND
See real difference	16%	16%	19%	15%
See no real difference	68%	69%	67%	70%
Not sure/Refused	16%	15%	14%	15%

Source: Kaiser/Commonwealth Health Insurance Survey

TABLE 14

Question -- Can you think of any political leader or candidate whose proposals for health care reform you support?

CANDIDATE	TOTAL	REP	DEM	IND
Bush	5%	9%	1%	6%
Clinton	2%	1%	3%	1%
Tsongas	1%	1%	1%	2%
Kennedy	1%	0	1%	2%
Kerrey	1%	0	2%	1%
Buchanan	0	1%	0	1%
Brown	0	0	0	0
All others	2%	2%	2%	2%
Don't know/Refused	7%	5%	7%	7%
No one	80%	80%	82%	77%

Source: Kaiser/Commonwealth Health Insurance Survey

TABLE 15

Question -- Overall, how do you feel about the health care services you and your family have used in the last few years?

	1987*	1990*	1992**
Very/Somewhat satisfied	84%	79%	71%
Very/Somewhat dissatisfied	13%	18%	26%
Not sure/Refused	3%	3%	3%

*Source: Louis Harris Surveys 1987, 1990

**Source: Kaiser/Commonwealth Health Insurance Survey

APPENDIX

SECTION ONE: THE PUBLIC'S EXPERIENCES, FEARS AND CONCERNS

I A HISTORICALLY, AMERICANS HAVE BEEN SATISFIED WITH THEIR OWN HEALTH CARE ARRANGEMENTS, BUT THEY ARE BECOMING INCREASINGLY DISSATISFIED

Question -- Overall, how do you feel about the health care services you and your family have used in the last few years?

	1987*	1990*	1992**
Very/Somewhat satisfied	84%	79%	71%
Very/Somewhat dissatisfied	13%	18%	26%
Not sure/Refused	3%	3%	3%

*Source: Louis Harris Surveys 1987, 1990

**Source: Kaiser/Commonwealth Health Insurance Survey

I B AMERICANS RANK THEIR TOP HEALTH CARE CONCERNS AND COMPARE THEM WITH OTHER MAJOR CONCERNS

Question--I will read you a list of things that people worry about. Please say for each one if it is something you worry about a great deal, quite a lot, not much or not at all.

	A great deal/ Quite a lot
..that health insurance will become so expensive that you won't be able to afford it?	61%
..that you will have to pay very expensive medical bills not covered by health insurance?	50%
..that you will not be able to get the health care you need when you are very ill because you can't afford it?	48%
..that your benefits under your current health care plan will be cut back substantially?	48%
..that if you have large medical bills, your health plan will refuse to insure you?	39%
..that your employer's health care costs will limit your wage increases?	31%
..that your employer will stop providing you with any health insurance?	26%
Answered at least one of the above: A great deal or quite a lot	**82%**
COMPARED WITH OTHER MAJOR CONCERNS	
..that you will not be able to maintain your standard of living?	50%
..that you or your spouse will lose your job in 1992?	33%

Source: Kaiser/Commonwealth Health Insurance Survey

I C A SIGNIFICANT NUMBER OF AMERICANS ARE HAVING DIFFICULTY GETTING THE CARE THEY FEEL THEY NEED

* Approximately 23 million Americans needed medical care but did not get it in the last 12 months. Approximately 18 million could not get medical care for financial reasons.

* Last year, 54 million people postponed care they thought they needed for financial reasons.

* About 7 million Americans report that they were denied health insurance because of a prior medical condition.

* Nearly 22 million Americans said they themselves, or someone else in their family, or both, had been refused health care during the last year because they didn't have insurance or couldn't pay.

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- During last year have you or has any member of your family been refused health care because you didn't have insurance or you couldn't pay?

% answering yes to respondent, family or both:

		TOTAL
Overall		12%
Income:		
less than	$15,000	16%
	$15,00-$50,000	11%
over	$50,000	10%
Private insurance		11%
Medicaid		14%
Uninsured		19%

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- In the last 12 months have you ever put off or postponed seeking health care which you felt you needed because you could not afford it?

% answering yes:

		TOTAL
Overall		30%
Income:		
less than	$15,000	39%
	$15,000-$50,000	31%
over	$50,000	19%
Private insurance		24%
Medicaid		26%
Uninsured		67%

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- In the past 12 months was there a time when you needed medical care but did not get it?

% answering yes:

		TOTAL
Overall		13%
Income:		
less than	$15,000	20%
	$15,000 - $50,000	12%
over	$50,000	7%
Private insurance		8%
Medicaid		13%
Uninsured		37%
(For those answering "yes") What was the main reason?		
Cost too much/not covered		77%
Could not get appointment		2%
Didn't know clinic/doctor		1%
Not easy to get to physician's office		1%
All others		15%
Not sure		4%

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- In the past 12 months was there a time when one of your children 17 years old or younger needed medical care but did not get it?

% answering yes:

		TOTAL
Overall		3%
Income:		
less than	$15,000	3%
	$15,000 - $50,000	4%
over	$50,000	1%
Private insurance		3%
Medicaid		2%
Uninsured		7%
(For those answering "yes"): What was the main reason?		
Cost too much/not covered		79%
Could not get appointment		3%
Didn't know clinic/doctor		5%
No transportation/too far		2%
All others		8%
Not sure		5%

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- In the last year about how much have you and your family had to pay out-of-pocket for medical bills which were not covered by insurance?

	TOTAL	Private Insurance	Medicaid	Uninsured
Nothing	22%	21%	44%	16%
$200 or less	21%	23%	13%	12%
$201 - $500	20%	21%	17%	21%
501 - $1,000	14%	15%	5%	18%
$1,000 and over	16%	14%	11%	31%

Source: Kaiser/Commonwealth Health Insurance Survey

MANY PEOPLE FACED WITH HIGH OUT-OF-POCKET COSTS EXPECTED INSURANCE TO PAY FOR THEM

Question -- Before you and your family ran up these medical bills did you know that they would not be covered by insurance, or did you expect insurance to pay much more of these costs?

For those who had out-of-pocket costs of $2000 or more:

	TOTAL	Private Insurance	Medicaid	Uninsured
Knew costs were not covered	59%	53%	45%	73%
Expected insurance to pay much more	36%	43%	55%	21%
Not sure/Refused	5%	4%	0%	5%

Source: Kaiser/Commonwealth Health Insurance Survey

I E MANY AMERICANS ARE WILLING TO TRADE CHOICE FOR LOW COSTS BUT DON'T SEE MANY LOWER COST OPTIONS

Question -- If you were offered a different health plan which limited your and your family's choice of doctors and hospitals in return for real savings in your out-of-pocket costs, how interested would you be in changing to this plan?

		INSURANCE		
	TOTAL	Private	Medicaid	None
Very interested/ Somewhat interested	55%	53%	48%	63%
Not very interested/ Not at all interested	43%	45%	45%	33%
Not sure/Refused	3%	2%	7%	5%

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- Is there a health plan through which you and your family could get the health care you need which is less expensive than the way you do it now?

	TOTAL	HMO Members	Non-HMO Members
Yes	9%	7%	9%
No	78%	83%	78%
Not sure/refused	13%	10%	13%

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- Have you ever taken steps to find a less expensive way of getting health care services or not?

	TOTAL	INSURANCE Private	Medicaid	None
Yes	45%	41%	18%	86%
No	54%	58%	82%	14%
Not sure/Refused	1%	1%	0	0

Source: Kaiser/Commonwealth Health Insurance Survey

SECTION II: MEASURING PROGRESS TOWARD HEALTH REFORM

II A AMERICANS WANT THE FEDERAL GOVERNMENT, NOT THE PRIVATE SECTOR OR STATE GOVERNMENT, TO PLAY THE LEAD ROLE IN HEALTH CARE REFORM

Question -- Who should have the primary role in providing health insurance to all Americans and controlling health costs?

	TOTAL	REP	DEM	IND
Government	60%	52%	69%	62%
Private sector	34%	43%	26%	35%
Not sure/Refused	6%	5%	6%	4%

Source: Kaiser/Commonwealth Health Insurance Survey*

Question -- If it's a choice between the federal government or the state governments, which do you think should take the lead in changing the health care system?

	TOTAL	REP	DEM	IND
Federal	62%	59%	64%	62%
State	30%	33%	28%	29%
Both Federal & State	3%	3%	3%	3%
Neither	1%	1%	1%	2%
Not sure/Refused	4%	3%	4%	4%

Source: Kaiser/Commonwealth Health Insurance Survey

*Party affiliation totals are based on self-identification, not actual registration

II B AMERICANS ARE INCREASINGLY HOLDING GOVERNMENT RESPONSIBLE FOR THE PROBLEMS WITH OUR HEALTH CARE SYSTEM

Question -- Looking at the problems you see with our health care system, which group or groups do you think are mainly to blame?

	TOTAL	REP	DEM	IND
Government	31%	29%	33%	33%
Doctors	25%	27%	24%	26%
Insurers	23%	25%	22%	25%
Hospitals	15%	17%	14%	16%
All others mentioned	25%	26%	24%	25%

Source: Kaiser/Commonwealth Health Insurance Survey

II C THE ECONOMY WILL BE THE DOMINANT ISSUE WHEN AMERICANS CAST THEIR VOTES IN THE PRESIDENTIAL AND CONGRESSIONAL ELECTIONS, AND HEALTH CARE WILL BE THE NUMBER TWO ISSUE ON VOTERS' MINDS IN DECIDING WHICH CANDIDATES TO SUPPORT

Question -- The next presidential election will be in November 1992. What two issues do you think will be of most importance to you in determining who you will support?

ISSUE	TOTAL	REP	DEM	IND
The economy	50%	55%	46%	51%
Health care	25%	24%	27%	24%
Taxes	11%	12%	10%	11%
Jobs	8%	6%	10%	8%
Education	7%	8%	8%	7%
Foreign policy/Aid	5%	7%	3%	6%
Abortion	4%	5%	3%	4%

(total responses exceed 100% because respondents were asked to name two issues)

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- What two issues will be of most importance to you in deciding which Congressman or Senator to support?

ISSUE	TOTAL	REP	DEM	IND
The economy	34%	38%	32%	36%
Health care	19%	17%	23%	19%
Taxes	12%	16%	10%	13%
Education	11%	11%	12%	11%
Jobs	6%	5%	8%	5%

Source: Kaiser/Commonwealth Health Insurance Survey

II D BUT HEALTH CARE WILL BE LESS OF AN ISSUE IN STATE ELECTIONS

Question -- What two issues will be of most importance to you in deciding who you will support for Governor or State Representative?

ISSUE	TOTAL	REP	DEM	IND
The economy	29%	33%	27%	30%
Education	21%	24%	22%	19%
Taxes	20%	26%	15%	21%
Health care	11%	8%	14%	12%
Jobs	8%	6%	10%	9%

Source: Kaiser/Commonwealth Health Insurance Survey

II E IN THE PRESIDENTIAL ELECTION, HEALTH WILL BE MORE SALIENT TO THE AGE GROUPS WITH THE GREATEST VOTER TURNOUT

Question -- What two issues do you think will be of most importance to you in determining who you will support in the presidential election in November 1992.

% citing health as one of top two issues:

	TOTAL
	25%
Age:	
18-29	16%
30-39	22%
40-49	30%
50-64	31%
65 & over	32%

(total responses exceed 100% because respondents were asked to name two issues)

Source: Kaiser/Commonwealth Health Insurance Survey

II P AMERICANS ARE DIVIDED ON THE MAJOR OPTIONS FOR HEALTH CARE REFORM

Question -- Which of the following ways of financing health care would you favor?

OPTIONS FOR REFORM	TOTAL	REP	DEM	IND
Play-or-Pay	33%	30%	36%	33%
Single-Payor	30%	27%	33%	30%
Tax credit plan	27%	32%	21%	27%
Leave things the way they are	2%	2%	0	2%
Not sure/Refused	8%	8%	9%	8%

Source: Kaiser/Commonwealth Health Insurance Survey

(Actual questions asked) A national health plan in which businesses are required to either offer private health insurance for their employees or contribute to a government program that would cover them. Those who are unemployed or work part-time would be enrolled in the same government program, financed by taxpayers. To control costs, government would set the fees charged by doctors and hospitals. **(Play-or-Pay)**

A national health plan financed by taxpayers in which all Americans would get their insurance from a single government plan. To control costs, government would set the fees charged by doctors and hospitals. **(Single-Payor)**

A national plan which would offer low- and moderate-income uninsured Americans an income tax refund to help purchase private health insurance. Those who are not insured would have access to care through tax supported public health clinics. To control costs, financial incentives would encourage enrolling in less costly health care plans. **(Tax Credit Plan)**

II Q AT THIS POINT, MOST AMERICANS DO NOT FEEL THAT ANY PARTY OR CANDIDATE HAS A REFORM PROPOSAL THEY CAN IDENTIFY OR SUPPORT

Question -- Do you see any real difference between the health care reform proposals of the Republicans and the Democrats, or not?

	TOTAL	REP	DEM	IND
See real difference	16%	16%	19%	15%
See no real difference	68%	69%	67%	70%
Not sure/Refused	16%	15%	14%	15%

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- Can you think of any political leader or candidate whose proposals for health care reform you support?

CANDIDATE	TOTAL	REP	DEM	IND
Bush	5%	9%	1%	6%
Clinton	2%	1%	3%	1%
Tsongas	1%	1%	1%	2%
Kennedy	1%	0	1%	2%
Kerrey	1%	0	2%	1%
Buchanan	0	1%	0	1%
Brown	0	0	0	0
All others	2%	2%	2%	2%
Don't know/Refused	7%	5%	7%	7%
No one	80%	80%	82%	77%

Source: Kaiser/Commonwealth Health Insurance Survey

II_B AMERICANS STRONGLY SUPPORT DIRECT GOVERNMENT INTERVENTION TO CONTROL HEALTH CARE COSTS

Question -- Should the government set the rates that insurers can charge for health premiums?

	TOTAL	REP	DEM	IND
Agree strongly/ Agree somewhat	75%	74%	78%	75%
Disagree somewhat/ Disagree strongly	22%	25%	20%	23%
Not sure/Refused	3%	2%	2%	2%

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- Should the government set the rates that doctors and hospitals charge patients?

	TOTAL	REP	DEM	IND
Agree strongly/ Agree somewhat	71%	69%	74%	74%
Disagree somewhat/ Disagree strongly	27%	30%	25%	25%
Not sure/Refused	2%	1%	2%	2%

Source: Kaiser/Commonwealth Health Insurance Survey

Question -- Should the government set the prices for prescription drugs?

	TOTAL	REP	DEM	IND
Agree strongly/ Agree somewhat	73%	69%	77%	74%
Disagree somewhat/ Disagree strongly	25%	30%	21%	23%
Not sure/Refused	2%	1%	2%	3%

Source: Kaiser/Commonwealth Health Insurance Survey

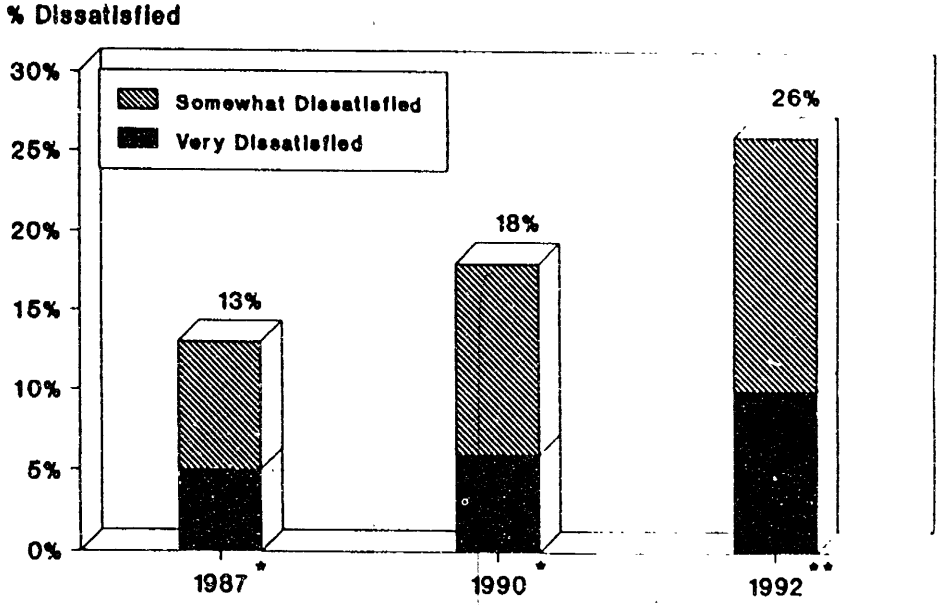
II I THE PUBLIC APPEARS TO WANT SUBSTANTIAL CHANGE ... BUT NOT A COMPLETE OVERHAUL OF THE SYSTEM

Question -- Which of the following best describes how you feel about the country's health care system?

	TOTAL	REP	DEM	IND
Works as well as expected	5%	8%	3%	4%
Works fairly well/ Minor changes needed	35%	40%	33%	35%
Works badly/ Major changes needed	38%	38%	39%	37%
Works so badly/ Different system needed	19%	12%	22%	22%
Not sure/Refused	3%	2%	3%	2%

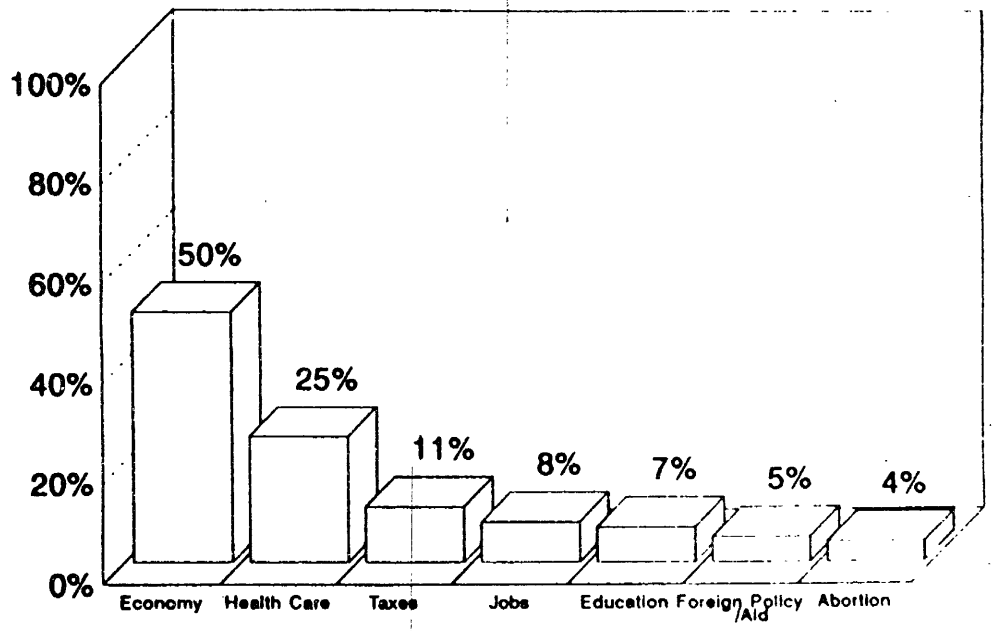
Source: Kaiser/Commonwealth Health Insurance Survey

Americans are increasingly dissatisfied with their health care



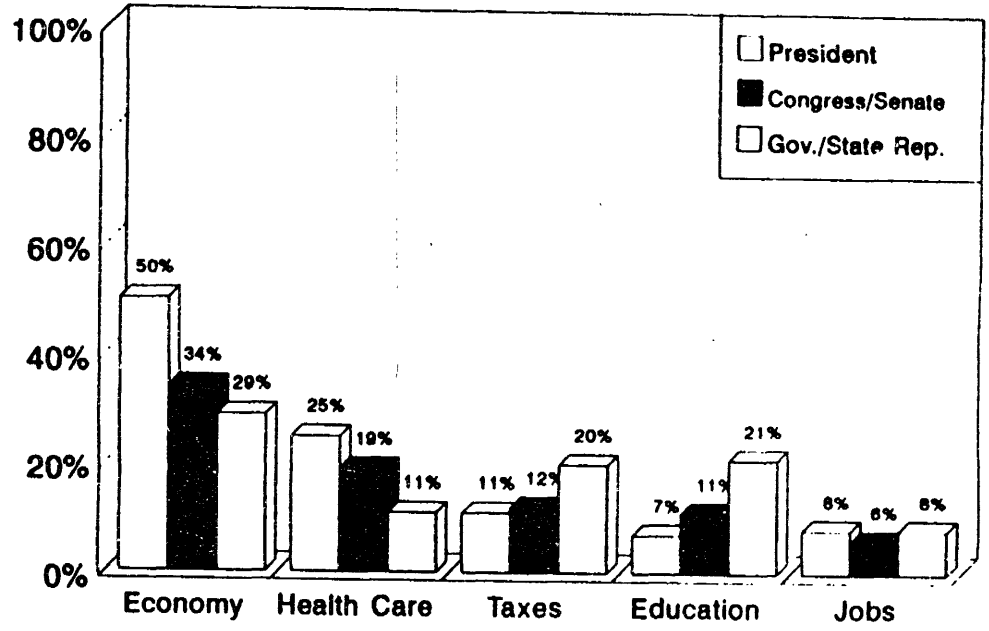
* 1987, 1990 Harris Surveys
** 1992 Kaiser/Commonwealth Health Insurance Survey

The next presidential election will be in 1992. What two issues do you think will be of most importance to you in determining who you will support?



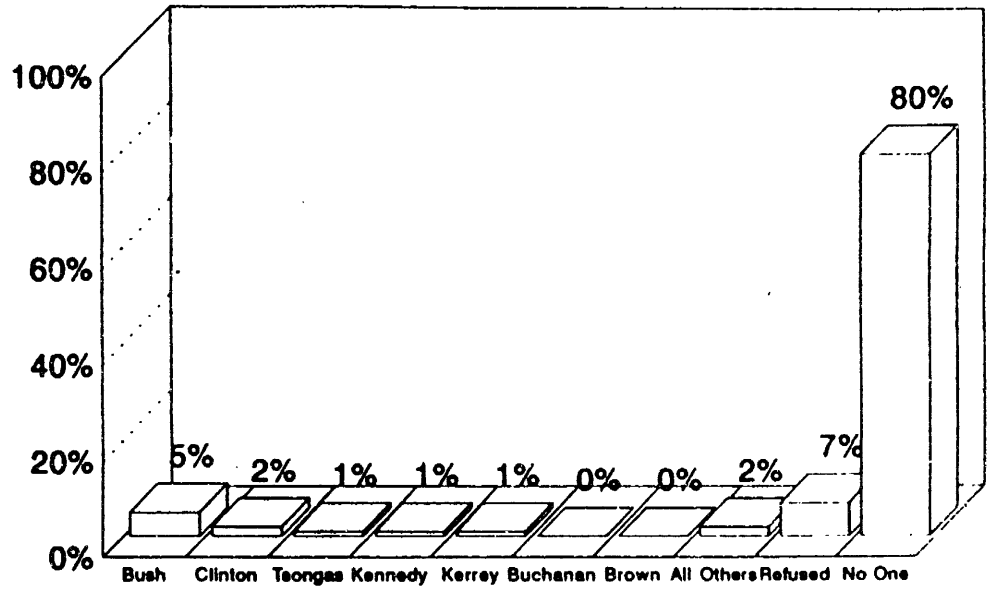
Source: Kaiser/Commonwealth Health Insurance Survey 1992
(total responses exceed 100% because respondents were asked to name two issues)

What two issues will be of most importance to you in deciding who you will support for President, Congress/Senate and Governor/State Representative?



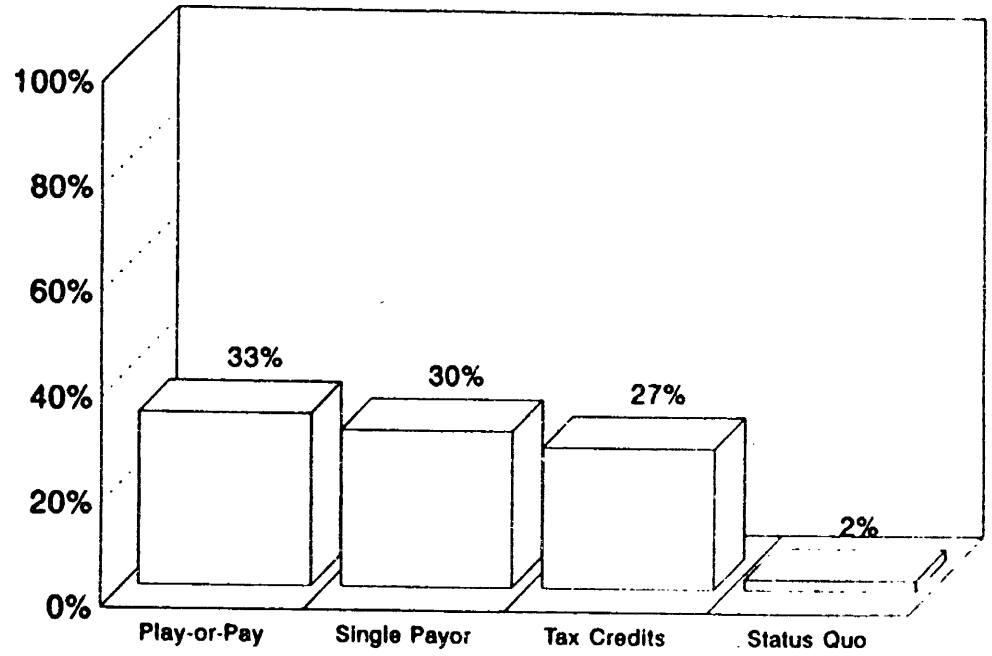
Source: Kaiser/Commonwealth Health Insurance Survey 1992
(total responses may exceed 100% because respondents were asked to name two issues)

Can you think of any political leader or candidate whose proposals for health care reform you support?



Source: Kaiser/Commonwealth Health Insurance Survey 1992

Which of the following ways of financing health care would you favor?



Source: Kaiser/Commonwealth Health Insurance Survey 1992

PREPARED STATEMENT OF STUART H. ALTMAN

Good Morning, Mr. Chairman and members of the committee. My name is Stuart Altman and I am currently dean of the Florence Heller Graduate School for Social Policy at Brandeis University. I also serve as Chairman of the Prospective Payment Assessment Commission (ProPAC) of the U.S. Congress. My testimony this morning, however, is my own and does not represent any group with which I am affiliated.

I appreciate the opportunity to appear before the committee this morning to discuss the pressing social issue of national health care reform. This is not a new issue for me or for the Congress. I had the privilege to appear before this committee many times during the 1970's in my capacity as Deputy Assistant Secretary of the Department of Health, Education, and Welfare to discuss this subject. Failure to complete our efforts 18 years ago, I'm afraid, has vastly magnified the problems, until today we face the very real possibility of a breakdown of our total health care system. That is, unless something meaningful is done and done soon.

In 1973, there were 15 million Americans uninsured; this country was spending about 8.0 percent of national income on health care or about $100 billion. Most working Americans did not question whether the health insurance coverage of their employer was in jeopardy or that if they developed a serious illness their policy would not cover the expense of any needed treatment.

All this has now changed. Upwards of 36 million Americans lack any health insurance protection. Millions more feel threatened that any major illness of theirs or their families will bring a cancellation of their coverage. At the same time total spending for health care consumes 14.0 percent of our GNP or over $800 billion a year; estimates are that such spending levels could reach 18.0 percent of our GNP or $1.7 trillion by the turn of the century. That is, unless something is done to slow it down. Of the 36 million uninsured, more and more are from middle income families who either work in firms that do not provide coverage or who have lost their jobs in the latest recession. Also included in these numbers are new entrants into the work force who have fallen between the crack, often losing family coverage but not qualifying for protection under any employer plans.

Among the many reasons fueling this breakdown in our health financing system is the structure we use to establish premiums for private insurance and the rise in health costs. With the health care inflation rate often triple that of the overall CPI, health insurance companies and private employers are constantly seeking ways to limit their expenses. Sometimes this translates into using the health care system more efficiently and this certainly is to be encouraged. But, constantly accelerating health costs are also driving insurance companies to eliminate coverage for some policy holders that incur or might incur large medical bills, or to charge them or their employers very high premiums to retain coverage. Health insurance premiums which used to be a small "fringe" benefit expense for most employers now amounts to 8 to 10 per cent of payroll for many firms and for some of our large industrial firms with an older work force, the cost of health insurance coverage could amount to as much as 20 percent of their payroll expense. It has recently been estimated that spending by all private employers for health insurance now exceeds in magnitude corporate net profits for the entire country. These very large expenses are forcing more and more firms to cut back on their coverage, to shift more of the cost onto their employees or in some instances to eliminate coverage altogether.

Adding to the financial pressure on our employer-based insurance system, which still covers most Americans, is the growing phenomenon of the shifting by providers of their unpaid expenses onto the bills of privately insured patients. Such shifting of expenses occurs in part because some of our uninsured do receive needed care, much of it in our most expensive health care institution, the hospital. ProPAC estimates indicate that uncompensated care costs for hospitals in 1990 approached $10 billion. Added to these unpaid bills are the extra expenses hospitals and doctors incur beyond what Medicare and Medicaid pay for the care of their beneficiaries which amounted to almost $13 billion. To compensate for these $23 billion in underpayment, hospitals charged private patients about 30 percent more for their care than it cost. These extra charges translated into higher private insurance premiums which fewer and fewer firms could afford, leading to further growth in the uninsured pool. Something real needs to be done to break this spiral.

PREFERENCE FOR PLAY OR PAY

I have long believed that we should build upon our employer based system, not destroy it. In the 1974 plan of the Nixon administration a strict employer mandate approach was used for working Americans. For those individuals who would not be covered by an employer plan, a government assisted program was proposed to be paid by income related premiums and government funds. I thought then and still

believe that we cannot leave the system open-ended—every American should be part of the program. The criticism then, as now, is that such an approach would put too much of a burden on small and low wage employers. For this reason the employer mandate approach was later modified to include the provision that a firm could choose not to offer coverage to their workers and instead pay an earmarked payroll tax into a fund which would provide coverage. For low wage workers or part-time workers the health insurance tax payment would be proportionately lower. This approach became known as Play-or-Pay and it is the approach which I believe is the most workable in the American economic system.

Some have criticized the Play or Pay approach because they fear that too many employers would choose to put their workers into the government program. While this possibility could be real, it is easy to correct; establish a higher tax rate or add restrictions on a firm's ability to choose the government program. I also believe that the potential of employers dropping their private coverage because the alternative tax payment is lower has been grossly overplayed. In a recent survey conducted by BUSINESS INSURANCE, most employers contacted indicated that even if the continuation of private coverage cost more they would not or could not drop their private plans. There were several reasons given for maintaining private coverage, including the need to maintain good employee relations or the desire of firms to keep control over their own expenses. There was also the fear that even if the government tax rate started out less expensive it would not stay that way.

To further limit the shifting of workers to the government program a compromise plan could be developed which would use the tax credit (deduction) approach of President Bush's proposal as a way to help low wage firms keep their workers insured privately. Maintaining private coverage would be aided by the insurance market reform provisions of the plan that you, Mr. Chairman, have proposed.

If the Congress and the President are serious in wanting to legislate meaningful reform of our health financing system, it is possible to do so and to do it using as its core our employer based system.

THE NEED FOR SERIOUS COST-CONTAINMENT

Most of the focus of the national debate about health care reform thus far has surrounded the differing approaches to restructuring our system of financing health care. I would submit, Mr. Chairman, that equal attention should be directed toward the issue of what system we should use to contain health care spending. If we do not, I believe any financing system we create will crack at some time in the future under the pressure of constant double digit growth in expenditures.

Even with our existing incomplete financing system we are supporting a health care industry that, as I indicated previously, has grown to over $800 billion. What is even more disturbing is the accelerating trend lines for the future. Many analysts look in disbelief at the possibility that we really could be spending 20 percent of our GNP by the year 2010. They say it just will not happen. I must admit, in the 1970's I could not believe we would ever reach the point where health care would consume 10.0 percent of our GNP, or as late as two years ago some questioned the projections of 15.0 percent of GNP by 2000. I no longer doubt any number.

Even faced with these incredible future estimates, some question Why the concern;—"Is not health care a needed human service;" or "will we have to give up too much to stop the growth in health spending?" All are legitimate comments, but miss the essence of the concern. That is, unless we bring health spending under control in relationship to our ability to pay for it, the continued viability of our health-care financing system and ultimately the system we use to deliver care are in doubt. There are already signs that we may be nearing the breaking point. Uncompensated costs are up and growing and the ability to shift these expenses onto private payers is eroding. More and more hospitals are operating at a loss or attempting to avoid caring for those who cannot pay. Yet the pressures to pay for more and more expensive technology, to add to the number of health workers, and to expand the health care delivery system continues unrelentingly.

To slow this financial juggernaut is not easy. Taking $80 to $100 billion out of the health system will lead to the loss of thousands of jobs; others will see their incomes go up much less rapidly. And yes, there will probably be less on-demand non-emergency care available. Clearly this is not a politically attractive package to offer. Therefore, the temptation to either do nothing to control spending or accept the approach; let market forces work though managed care—is very appealing. Market competition sounds benign and painless. And maybe it is? That is also its problem, it will not work alone. Slowing the rate of growth in total health spending will take much stronger medicine.

Not that I am against managed care. I think it should be part of any total system to control spending. It just is not powerful enough to be the only weapon used. As long as there is an almost an unlimited flow of money available to the health care system, it will be used. Managed care might reduce somewhat the rate of growth in health spending or restructure where the money goes or who ultimately bears the burden of paying for it, but it is just too weak by itself to substantially slow the growth of an $800 billion steam roller. It is possible to spin out very enticing theories on why market competition will be effective. At the center of the argument is that consumers of health care will select the lowest cost managed care group in relationship to the quantity of services and the quality of services each plan provides. So the argument goes, this would put sufficient pressure on the plans to control their spending.

To be accurate, there are examples of where managed care has been effective in limiting the use of expensive medical care and in controlling total health care spending in the area. But, such situations are, at best quite limited. What these theories fail to grasp is the complexity of our current financing system, particularly the massive amount of cost shifting that could be exacerbated under some versions of the managed care plans being proposed. The critical factors are whether the uninsured problem would be eliminated under the proposal and the rates government would pay for the care its beneficiaries use. But, why should government pay the same rates as the managed care plans if it believes the rates are too high? Why should government give up its power in the marketplace unless it can see other benefits? I do not think it should unless all the uninsured are covered and it joins a system with limits imposed on total expenditures. Such an "all-payer" system need not require every group to pay the same rate. As I will discuss below, certain forms of negotiated prices should be permitted.

There is also the issue that Americans, like citizens of every other country, do not want price to govern their choice of health care. They want to be shielded from the fiscal realities of the high cost of health care. Once price stops being a critical factor, competition among provider plans moves in other directions—higher quality, more amenities, and greater availability of services. All which ultimately add to the total cost of care.

I agree with the advocates for managed care that we need to make managed care work better. One possible way to do that would be to impose tough budget constraints which would limit the ability of the total system to add uncontrolled amounts of spending. The decision on how much new revenue should be added or whether revenue should be reduced from the system could be determined by a *National Health Care Expenditure Board* and a system of regional Health Care Expenditure Boards. Such a system could be set up similar to the Federal Reserve System and be independent of the day-to-day activities of government.

First the decision would need to be made on what rate of increase should be allowed nationally. Then expenditure limits would be allocated to each region on an adjusted per capita basis. Based on these limits, each regional Board would determine the permissible increases in premiums for fee-for-service insurance or capitated managed care plans. Each insurance carrier or plan would be required to take all applicants and charge the same premium to all enrollees. Each plan would need to be large enough to minimize adverse selection. If a plan could demonstrate, however, that they provide care to a sicker population, the regional Board could authorize a subsidy above the standardized premium rate. Such subsidies would come from a fund established in each region and financed by a small tax imposed on all premiums in the region. Plans that are more successful in managing the care of their enrollees could use the savings to increase services or provide price dividends. Such dividends would be monitored by the regional boards to assure that they are not being generated by unacceptable forms of patient selection.

So as to eliminate the cost shifting schemes now in effect, all plans would be required to pay a provider the same amount for the same service. An individual plan could be less costly by choosing lower cost providers or by managing the care used by their enrollees more effectively. They could not use their market power, however, to extract from a provider the same service for less money. This limitation would also apply to government programs. For example, each plan would pay the same rate for the same illness in the same hospital. But, if a plan had their patients stay a shorter time in the hospital or if it consistently used less services or procedures for the same diagnosis, the plan and the hospital could negotiate a lower rate.

Within each region, negotiating units of providers and payers would be established to determine the basic rate structure for each type of service. The regional Boards would monitor these activities to make sure that the rate structures do not generate expenditures in excess of the limits. The regional Boards also would be re-

sponsible for assuring that all individuals in the area had some form of acceptable coverage.

The National Board would oversee the entire system and determine the total expenditure constraint. The established revenue target should be related to the growth in the nation's income, but I would not create an arbitrary fixed relationship. Instead, I would allow the Board discretion to set the limit consistent with its assessment about the trade-offs between the growth in health spending and other national priorities. I would also require them to assess what level of expenditure is needed to support a cost effective health care delivery system.

Mr. Chairman, this is just a sketch of one possible approach to establishing a national expenditure limit for health care. It could be modified to be more or less regulatory. There is more than one approach that will work. Regardless of which approach is selected, it is critical that it be permitted to work. What has not worked in the past is our constant jumping from one system to another. In a recent article, I likened past cost-containment efforts as promoting "half-way competitive markets or ineffective regulation." This time around, I would hope that we would not repeat the mistakes of the past. I also hope that we don't let this time pass without doing something meaningful. If we choose to do nothing as we did in the 1970s, and let the current trend lines continue, it is hard to imagine where it will end. What will our system look like with 50 million uninsured, with health care consuming one out of every five dollars of national income and with the burden on private companies for health insurance approaching 25 percent of their payroll. Further, as health care grows as a proportion of our national income it will squeeze out spending for other priorities. But where will the money come from to improve our educational system, to expend our R&D efforts, or to clean our rivers and cities?

We need to assure financial protection to all citizens against the high cost of health care, while at the same time limiting the growth in health care spending. No one approach thus far developed for health care reform seems to have sufficient political backing to become law, Compromise, therefore, is required. I hope in my testimony today, I have helped to develop a plan which could bring the various groups supporting reform together.

Than you, Mr. Chairman, for the opportunity to speak to your committee on this most important social issue.

PREPARED STATEMENT OF ROBERT M. BRANDON

Mr. Chairman and members of the Committee, I want to thank you for the opportunity to testify today and congratulate you on holding these critical hearings. My name is Robert M. Brandon and I am vice president of Citizen Action a nationwide advocacy group representing 32 state organizations with 3 million members.

The problems of rapidly escalating health care costs are evident throughout our society. Health care spending is on a course which OMB Director Richard Darman appearing before this Committee, has correctly labelled "unsustainable." Total health care costs and per capita costs are more than doubling every decade, a trend that, if maintained, could result in over one-quarter of the entire Gross Domestic Product being spent on health care by the year 2030. Clearly, the United States cannot continue along this path and guarantee that those Americans currently insured remain so. Effective cost containment is also a prerequisite for measures designed to expand access and comprehensiveness of coverage. Without significantly improved efficiency, those measures will simply add fiscal pressures to a system already crumbling under the weight of excess expenditures.

The question before this Committee, Congress, the White House and the entire nation is not whether to constrain health care spending but how to do so in a manner that meets the following critical policy goals:

• *Efficiency:* The argument has been compellingly and repeatedly made that having the most expensive health care system in the world has not resulted in the United States having the best health care system in the world, either in terms of access or health quality indicators. Equally as compelling has been the argument that the United States could achieve the goals of universal access and a healthier population by making the system more efficient instead of more costly, either in terms of total expenditures or costs to individual consumers or sectors. Cost containment strategies should, then, focus on achieving efficiency gains in the areas most responsible for excessive spending: administrative costs, excess capacity, high fees and prices, and unnecessary services.

The difference between spending fewer dollars and spending fewer dollars more wisely is an extraordinarily important distinction. The experiences of other countries demonstrate that efficiencies can be maximized through systemic reform that

utilizes economies of scale, addresses health care planning on a system-wide basis, increases the percentage of public expenditures for health care, emphasizes prevention, and develops comprehensive payment mechanisms that take into account per unit cost, volume and service intensity factors. As will. be discussed later, Citizen Action believes that these are essential cost control mechanisms.

• *Universality and Comprehensiveness:* If constraining health care spending were the only ingredient in the current debate, then certain approaches might be less debatable: explicit rationing as proposed by Oregon; implicit rationing as proposed by managed care advocates; elimination of state mandated benefit and other laws, as proposed by small group insurance reform advocates; cost-sharing requirements; and exclusion of necessary benefits from the basic benefit package proposed under various "pay-or-play" approaches. The controversial nature of these approaches arises from their incompatibility with two other policy goals: first, the consideration of health care as a right available to all Americans; and, second, the improvement of access to medical care through expansion of covered services (including prescription drug coverage, mental health services, substance abuse treatment, long-term care services, and rehabilitative services) and elimination of financial obstacles to care.

By following a cost containment strategy achieved through efficiency gains, those non-cost goals can be treated not as competing but as complementary goals. Cost containment strategies which do not maximize efficiency gains will, of necessity, sacrifice some degree of universality or comprehensiveness. Even where there is a commitment to those goals, insufficient savings will accrue to allow them to be achieved. On the other hand, there are cost containment mechanisms which actually depend upon devising obstacles to comprehensiveness: elimination of state mandates, basing access to certain benefits on income, and using cost-sharing and restrictions on freedom of choice as means to reduce utilization.

• *Equity:* In designing cost containment and other health care strategies, equity concerns must play a central role. Unlike other industrialized countries, the United States does not have even a theoretical commitment to providing access to health care to all its citizens. Several members of this Committee are to be commended for having introduced legislation to make and translate that commitment into actual policy. In moving from commitment to reality, however, attention must be paid to several equity issues: the progressivity of financing mechanisms, the comprehensiveness and quality of services available to all Americans, the continued possibility of rationing by income, and the ability for consumers—individual and business alike—to participate in the decisionmaking process. For example, financing systems based on premiums, commodity taxes, or health care utilization are not only regressive but, unless accompanied by severe penalties which are themselves regressive, will prevent universal access. Mandated benefit packages which fail to include prescription drug benefits, adult preventive services, long-term care services and durable medical equipment will result in an unequal health care system in which only the wealthy or those working for certain employers have access to necessary services.

The question of equity is particularly serious in health care approaches that fall to substantially reduce overall costs but, instead, shift costs from some payers to others. In the current small market reform debate, for example, the approach is to ameliorate the cost problems of some small businesses whose employees are at risk for higher health care spending by limiting the possible variation in premium rates among all small businesses. Instead of lowering costs for all payers—the goal of a cost efficiency strategy—insurance company actuaries such as Ken Seminatore, representing Blue Cross & Blue Shield of Ohio, have testified that the effect of small group reform would be to raise premiums rates for some small firms by 20% and to "increase premiums for all small groups, by an average of 10%, on top of normal annual inflationary increases in premiums." These reforms also allow massive cost-shifting to small business employees through increased premium costs (through higher premiums even if the employee share were to remain constant), higher deductibles and copayments, and reductions in benefits through elimination of state mandates. Again, equity issues are paramount in a strategy which creates many losers and potentially few winners.

Citizen Action supports enactment of a single-payer health care system, as embodied in S. 2320, the Universal Health Care Act of 1992, because we believe that it provides the best opportunity to achieve the goal of increased cost efficiency while ensuring that the other goals of universality, comprehensiveness, and equity are met. The remainder of this testimony represents Citizen Action's recommendations for components of a cost efficiency approach and a discussion of the problems with the managed care and cost-sharing approaches suggested by others.

KEY COMPONENTS OF A COST EFFICIENCY STRATEGY

Administrative Savings: The ability to achieve cost efficiency savings through changes in health care administration has been recognized by all participants in the health care debate. Estimates of potential savings, however, vary dramatically, as do proposed measures.

The President's February 6 proposal suggests a two-fold approach to administrative costs: (1) streamlining the claims process through standardization of forms and electronic processing, and (2) allowing small businesses to form Health Insurance Networks to achieve economies of scale. The President's own estimates of possible savings from this combined approach, however, demonstrate that small businesses would still pay significant administrative costs. For firms with 1 to 4 employees, health insurance overhead costs as a percentage of premiums would decrease from 40 percent to 24.1 percent. Firms with 20–49 employees would pay 16.5 percent of premiums for administration, even with the savings. Paperwork reduction initiatives are estimated to save up to $4 billion a year, health insurance market reform up to $9 billion a year. Employers and employees in smaller firms would still pay higher rates based on workforce size.

Those cost savings figures should be compared with the U.S. General Accounting Office's estimate that $67 billion in administrative costs could be saved if paperwork reduction and economies of scale were obtained through a single-payer mechanism. According to a study by the Economic ad Social Research Institute, *A National Health Plan in the U.S.,* the U.S. could have saved $72 billion in 1991 in administrative savings alone (not excluding spending on physician incomes, intensity of care, technology, and other areas of savings) if we been able to obtain only about half of the administrative savings achieved by Canada. Even opponents of single-payer reform admit that total administrative savings in such a system would be between $31 billion and $49 billion, significantly higher than the savings claimed by proponents of market-based or employer mandate approaches.

In a report released last month, Citizens Fund, Citizen Action's research affiliate, compared the efficiency of one portion of the private insurance market—commercial insurers—with that of the U.S. Medicare and the Canadian systems. The report, *Premiums without Benefits, 1990: The Decade-Long Growth in Commercial Health Insurance Industry Waste and Inefficiency,* found that over the last decade, the commercial health insurance industry became increasingly inefficient. By 1990, commercial health insurers were spending 37.2 cents for administration, marketing and overhead to provide a dollar's worth of health care benefits to policy holders. Not including profits, they spent more than 40 times as much on administration per dollar of benefits provided as the Canadian national health system and 18 times as much as the Medicare system. (The Canadian system spent 0.9 cents per dollar of benefits, Medicare 2.1 cents.) Had a system as efficient as Canada's provided the same amount of benefits as provided by the commercial insurers, the nation would have saved $16.7 billion. Not included in this estimate are the profits of commercial insurers and the administrative expenses of insurance firms for whom comparable data is not available. Nor are the administrative costs the insurance companies impose on doctors, hospitals, businesses and consumers counted.

The efficiency of the commercial health insurance industry has declined over the last decade. The 37.2 cents it cost commercial insurers to deliver a dollar of benefits is a 6.5 cents per dollar of benefits increase over 1981 and a 10 percent increase over 1988. Commercial insurers retained 24 percent more of the premium dollar for administration and profit in 1990 than they did in 1981. In sharp contrast, the administrative cost per dollar of Medicare benefits declined between 1981 and 1990, from 2.9 cents to 2.1 cents.

The study also found that:

- Between 1981 and 1990, administrative spending by the commercial insurance industry increased by 122 percent while benefits delivered increased by only 83 percent. Thus, during the last decade, administrative spending rose 50 percent faster than benefits paid.
- Administrative costs amounted to at least $330 for typical individual coverage under employer-provided plans and $830 for typical family coverage under employer-provided plans in 1990. Had benefits been provided as efficiently as they are by Medicare, the cost for an individual could have been reduced by $300 and for a family by $750.
- Administrative expense was even greater for those who could not obtain group coverage. Commercial insurers spent 68.2 cents to deliver a dollar of benefits in 1990 to policy holders who were not part of regular group plans.

In *Universal Health Insurance Coverage Using Medicare's Payment Rates,* (December 1991), the Congressional Budget Office also pointed out the larger administrative savings potential of a single-payer, as opposed to an all-payer mechanism:

> Under a single-payer system, the consolidation of numerous private insurance plans ad government health programs into one insurance system for basic coverage would reduce total expenses for insurance overhead. Under a universal health plan, determining eligibility would be inexpensive, since essentially everyone would be covered continuously under the same plan. There would no longer be any costs for marketing or assessing risk to calculate premiums. Paying claims would be simplified because only one set of reimbursement rules would apply, and there would be no need to coordinate among multiple insurers. Further, no profit would be claimed under a public plan.

The single-payer approach achieves savings in other ways compared with market-based and pay-or-play approaches which rely on employer actions. The coupling of employment and insurance requires that employers undertake administrative responsibilities that would be unnecessary under a single-payer plan, responsibilities such as enrolling new employees and dependents (a one to two month process that is particularly burdensome for those firms with high turnover rates—uninsured workers typically spend only 5 to 11 months on the job, two to three times the average for all firms), determining the costs of private and public insurance options in light of their current and future employees' health needs and insurance industry practices such as churning, providing retiree health benefits, tracking claims denials, and so on. (While employees would also benefit from a reduction in administrative burdens—a particular problem when family members are covered under different plans—those benefits are not elaborated on here since these administrative costs are not included in overall cost analyses).

While a single-payer approach would maximize administrative savings, it should be noted that Germany has taken two important steps to increase cost-savings through its multi-payer plan. First, it has ensured that the vast majority of its population is covered by not-for-profit sickness ends (characterized as "quasi-public" by the U.S. General Accounting Office) and that the for-profit insurance industry's role is limited. Second, it has sought to minimize the administrative (and social) impacts of adverse risk selection. The majority of the insured are given no choice among funds; others can choose among funds (the wealthy can opt for private insurance but then may not enter the public plan). Members remain with the same fund, unlike the situation in the United States where many companies (and their employees) change insurers every few years.

Global Budgets, Fee Schedules and Expenditure Caps: The experience that the members of this Committee have had with the Medicare program underscore the cost savings potential of prospective payments for hospitals and physicians. While the steps already taken have had a beneficial effect on Medicare spending, additional measures are required to add to cost efficiencies.

First, it is important that reimbursement rates be standardized. Currently, public programs ad private insurers (including self-insured plans and managed care networks) establish different reimbursement rates which may lower expenditures to their own members but which are unlikely to lower system-wide expenditures. Whether set through government regulation or through negotiations between private payers and providers, the lack of uniformity in reimbursements not only allows providers to cost-shift but allows at least some providers to accept or provide more services to those willing to provide more generous fees and to reject those making less generous payments.

Second, to the extent that rates are established through negotiation (as in Canada and Germany), it is essential to provide adequate authority to the negotiator. In Canada, this is accomplished through provincial government negotiations of behalf of their entire population. In Germany, where individual sickness funds negotiate on the basis of a nationally-establish relative-points value scale, physician payments vary widely based on the market power of the fund. The lack of a single negotiator results in large variations in the percentage of payroll spent on premiums, ranging from 8 percent to 16 percent, a differential that the Germans are seeking to reduce.

Third, to avoid the health care "balloon effect," payment mechanisms must address issues of price, volume and intensity concurrently. International comparisons, for example, demonstrate that the high rate of spending in the U.S. is not attributable to higher provider contacts (OECD figures show that Americans have 5.3 visits/consultations per capita compared with 6.4 for Canadians and 11.5 for Germans) or more frequent hospital stays (again, OECD figures shows that residents of other countries are both more likely to enter a hospital and more likely to stay longer).

Rather, cost differentials are more likely to be attributable to higher prices in the United States (surgical fees are 3.2 times as expensive in the United States as in Canada; physician fees 2.4 times higher) and the intensity of high-cost technology.

Basing a strategy only on controlling unit prices, however, would likely result in increased volume if providers act to maintain income. As this Committee's experience with the Medicare physician payment structure indicates, cost efficiency strategies are necessary that deal coherently with all components of provider costs. In a fee-for-service system, that requires the use of expenditure caps; for institutional payments, global budgeting is a more promising cost efficiency measure in that it reduces the paperwork burdens of a DRG-type reimbursement mechanism; eliminates problems with unbundling of services or recoding procedures to obtain higher rates; reduces incentives to increase admissions; and, if established comprehensively, would prevent hospitals from cost-shifting to ancillary services, pharmacies or out-patient departments. Global budgeting for health care institutions in particular and expenditure caps for overall health care spending in general are much more likely to be successful with a single, rather than multiple, payers.

Fourth, expenditure ceilings must be as enforceable and as inclusive as possible. The German experience with targets versus enforceable caps, as described in GAO's *Health Care Spending Control: The Experience of France, Germany, and Japan,* demonstrates this. From 1977 to 1985, physician care expenditure targets resulted in a 7 percent average annual growth rate. Between 1985 and 1987, when a binding spending cap was in operation, the average annual rate of increase was 2 percent.

Clearly, cost containment strategies are more effective when a greater share of health care spending is subject to enforceable reimbursement mechanisms. Strategies that limit application to only certain categories of services or providers or to only certain populations allow providers to obtain higher payments elsewhere. The United States is the only OECD country in which public expenditures account for less than half of total health spending and less than half of spending for ambulatory and inpatient care. But other countries also provide significant public coverage for medical goods, including pharmaceuticals. Germany, for example, covers over 92 percent of medical goods (compared with only 34 percent in Canada), allowing it to achieve greater cost containment.

Additionally, it is important that the rates set under enforceable ceilings be inclusive. Allowance for balance billing adds to costs (placing the burden on individual payers, many of whom may be financially burdened) and provides incentives to providers to treat private pay patients in order to maximize their incomes.

Rational Resource Allocation: Roemer's Law—that the supply of health care facilities generates use (and therefore expenditures)—emphasizes the need for an effective cost efficiency strategy to address the issue of technology and resource allocation. Excess capacity, competition on the basis of "duplicated" technology, and the financial incentives on the part of hospital administrators to utilize high-cost, high-technology equipment in order to recoup investment (sometimes at the expense of quality of care) are other factors which necessitate action. Finally, on a non-cost containment note, the explosion of surgical centers that perform too few procedures to ensure favorable outcomes suggests that consumers have a strong quality incentive to adopt a "Centers of Excellence-type" strategy.

The United States lags behind other countries in this area. In Germany and Canada, for example, hospital budgets separate operating from capital expenditures and hospitals must receive approval from regional governments before making capital investments. Capital expenditures are part of the overall budget process as well, with regional governments assessing competing needs—to more efficiently and equitably distribute resources.

As this country's Certificate of Need experiment displayed, the efficacy of health planning is severely undermined when only certain providers are covered (restrictions on inpatient settings can be avoided by shifting expenditures to outpatient settings), when the regulatory decisionmaker does not also have control of capital and operating budgets (where decisionmakers are not the major payers, fiscal control incentives are reduced), and where providers are allowed to raise separate funds for capital expenditure requests which have been rejected (particularly when the operating costs attributable to those expenditures are then reimbursed).

The health planning mechanisms which would be established in S. 2320, as well as in S. 2513 and S. 1446, correct those problems and allow decisionmaking to occur at the state and local levels with full participation by consumers and providers.

Practice Guidelines and Technology Assessments: The need to reduce the level of unnecessary procedures which both add to costs and expose patients to unnecessary risk is evident. Studies have reported that 64 percent of carotid endarterectomies and 44 percent of coronary artery bypass graft surgery is either inappropriate or equivocal; that 27 percent of hospital days are inappropriate. Unnecessary services,

according to Dr. Paul Elwood, may account for up to $200 billion of annual health care costs. The need for accelerated work on outcomes research, practice guidelines and technology assessments is widely recognized ad relatively noncontroversial.

Prevention, Wellness and Alternative Providers: Similarly noncontroversial is the need for expanded emphasis on preventive services, early intervention and alternative providers. (Ironically, the elimination of state mandates under small group market reform could jeopardize state efforts to make improvements in the provision of preventive services, particularly in the area of mental health and the treatment of alternative practitioners.) What is more debatable is what services should be provided under basic benefit packages or the single-payer plan. Citizen Action urges this Committee to adopt a benefit package that is as comprehensive as possible, not just in terms of the inclusion of prescription drugs and other services that will contribute to the maintenance of health but also in terms of providing reimbursement to alternative practitioners such as physicians' assistants, nurse practitioners, clinical social workers and others who can provide quality health services efficiently. We also urge the Committee to go beyond benefit packages which define preventive services only in terms of well-baby and well-child care in order to provide all effective preventive care, including mental health services, to all members of the population, regardless of age.

DEFICIENCIES OF MANAGED CARE AND COST-SHARING APPROACHES

Managed Care: Vaguely-defined, ever changing, and widely agreed to be less than successful in effectively controlling costs, there are those who advocate managed care as the major building block for reform. While managed care is clearly allowed to function within a single-payer framework, advocates of various pay-or-play and insurance reform approaches are so convinced that managed care represents a cost containment solution as yet unfulfilled, that they are eager to set up financial carrots for its widespread use and financial sticks for those seeking to exercise freedom of choice.

There are, of course, examples of managed care delivery systems which have controlled cost increases while maintaining high consumer satisfaction (typically, their members have significant decisionmaking authority). But, while the experiences of managed care delivery systems vary as dramatically as do their structure, ownership (the fact that private insurers in 1990 owned 43 percent of all HMOS and 70 percent of PPOs is cause for consumer alarm), benefits, and cost-sharing requirements, the overall evidence suggests that premium rate increases for managed care do not differ substantially from increases for conventional plans. (The HIAA Employer Survey, 1989–1991, reports that managed care plans increased an average of 15% annually, compared with a 17% annual increase for conventional plans.) Cost reductions tend to be a one-time savings, employers are frequently dissatisfied with cost-savings through managed care, and managed care plans are beginning to employ practices more commonly associated with conventional insurance, such as experience-rating and cost-sharing.

The real question which this Committee must consider is how managed care networks seek to control costs and whether those strategies are the most efficient and most beneficial possible. In general, managed care strategies center on three cost control approaches:

(1) Negotiating payment terms with selected providers
(2) Limiting or influencing the choice of providers
(3) Intervening in the delivery of health services

In fact, managed care networks—particularly those which control a large share of local markets—have been somewhat successful in reducing costs through provider negotiations and contracts. The problem, as discussed above, is that those savings can be cost-shifted onto other payers. System-wide payment negotiations and standardized rates are more likely to result in greater overall savings and are more equitable.

The limitations on choice of provider achieve cost-savings in two ways: first, members are diverted to providers who have agreed to accept discounted rates (an unnecessary measure under an all-payer or single-payer construct). Complaints about difficulty in reaching schedulers, waits for initial appointments, and delays in obtaining care by specialists abound among managed care participants. One of my own colleagues, for example, had to wait over two months between the time his general practitioner indicated that his son needed surgery until the surgery was accomplished, simply because the HMO contracted with only one specialist who could perform that surgery and because that specialist spent only one day a week taking HMO members and performed surgery only one morning a week. More serious is

the case of the Fitzwilliams family in Wisconsin, whose HMO refused to cover the costs of their 3-month old daughter's biliary atresia, a life-threatening liver ailment that afflicts about one in every 50,000 to 75,000 newborns. This type of rationing may control costs but does so that the expense access to of needed health care.

Third, managed care networks intervene in the delivery of health care services in a number of ways: prospective and retrospective utilization review, financial incentives for physicians to reduce utilization (such as bonus distributions and withhold accounts), and encouragement of preventive services as opposed to hospital care. While utilization review of practice patterns is an important cost control strategy, the indications are that too many managed care networks have used it to deny needed care to their members. Increasingly, the same insurance companies that are overruling physicians' clinical decisions and denying claims payments to conventional insurance policy holders are doing the same in managed care operations, using financial rewards and penalties to enforce physician compliance.

Finally, there is growing evidence that even where managed care networks reduce their costs, payers may not benefit from those reductions. The issue of "shadow pricing" is becoming a serious concern, the practice of managed care networks reducing premiums just enough to attract payers and pocketing the difference or using savings to boost provider payments. A study by the Champaign County Health Care Consumers, found that, despite substantial deck in utilization rates, a local HMO significantly increased premiums ad provider payments (not surprising, since a majority of the Board was comprised of providers with contractual arrangements with the HMO).

Cost-Sharing: A number of approaches use cost-sharing requirements not primarily as a financing mechanism but as a means to reduce utilization. Despite the recognized administration costs, (particularly where cost-sharing is income-based), this argument holds that costs of $18 billion or more are offset by anticipated reductions in consumer demand.

In Citizen Action's view, this argument suffers from several flaws. First, if cost-sharing were an effective cost reduction strategy, it would be expected that the United States would have benefitted from the practice. Out-of-pocket costs account for 21 percent of health care spending in the United States, as compared with 7 percent in Germany for example. Yet, higher consumer point-of-service payments have not eased U.S. medical inflation.

Second, the argument assumes that U.S. consumers make utilization decisions while the evidence is that providers make the majority of those decisions. As the Congressional Budget Office concluded in *Rising Health Care Costs: Causes, Implications and Strategies,* "Physician-induced demand, however, suggests that demand-side strategies may be largely ineffective since physicians are able to offset consumers' decisions, at least partially. In that case, cost control may be more effective if applied through regulatory controls on the supply side." This may be one reason that CBO estimates savings of only $6 billion to $12 billion with a 50% increase in average coinsurance costs from 21 percent to 31 percent.

Third, the assumption that cost-sharing requirements can reduce inappropriate instead of appropriate care is highly debatable. In fact, the Rand study found that there was little difference in utilization due to cost-sharing once contact was made and little difference in inpatient services (suggesting, again, that providers and not consumers are in the utilization driver's seat and that consumers, given the nature of medical diagnosis, have ceded decisionmaking authority to their physicians). The real effects of cost-sharing were to discourage initial contacts with providers and, for lower-income families, to discourage appropriate and inappropriate care alike.

Fourth, the assumption that cost-sharing burdens can be made equitable is also highly questionable. While many proponents have made good-faith efforts to protect persons living below poverty, the cost-sharing requirements for many low-wage (and even moderate-wage workers) still present financial obstacles to care. Financial burdens which prevent moderate-income families from entering the health care system or place burdens on them for care which their physicians have determined is appropriate (for example, hospital care) will not meet the goals of universal access and comprehensiveness of care. And, if the arguments on physician-induced demand are correct, they will not result in the cost efficiencies.

In sum, both exclusive or undue reliance on managed care and cost-sharing requirements are less likely to lead to significant price reductions and any reductions which do occur are likely to result from implicit rationing rather than efficiency gains. Each approach also fails to meet the equity test since the financially-better off among us are guaranteed better access in that they can both afford to pay for services outside of managed care networks ad are relatively unaffected by coinsurance requirements. Oth approaches, we believe, are inherently inferior to the cost efficiency strategies laid out in the earlier part of this testimony.

Once again, Mr. Chairman, I appreciate the opportunity to testify before you and look forward to working with you and other members of this Committee in developing, enacting and implementing a health care program which will contain costs efficiently, provide universal access, and guarantee the comprehensiveness of care necessary to protect and maintain the health of all Americans.

RESPONSE BY ROBERT BRANDON TO A QUESTION SUBMITTED BY SENATOR WELLSTONE

Question. Ms. Steelman commented on the lack of consensus among Americans on the best road to health care reform. We have also seen recent reports about tremendous levels of campaign contributions by the health industry with the explicit goal of blocking comprehensive health care reform, an effort rivalled in earlier periods such as the mid-1960's and mid-1970's when comprehensive reform was seriously considered. Can you comment on information with which your organization is familiar regarding the preference of Americans for federally-based health care reform, as opposed to incremental or privately-based reform? Can you present your professional opinion on the kinds of information that has been presented to the public regarding the advantages and disadvantages of national health care reform?

Answer. Citizen Action's experience—based on talking with over 8 million households each year throughout the country, responses from our membership, and our work with state legislators and health care policy makers—is that the American people want comprehensive health care reform that guarantees affordable access to all. Citizen Action state organizations have worked on incremental reforms such as continuity of coverage and other insurance-based measures. Increasingly, however, we are finding that those incremental steps do not receive widespread popular support, largely because they have failed to improve the health care crisis in a significant fashion.

From Cobb County, Georgia to Portland, Maine to Spokane, Washington, we are receiving a common message. People generally we now have an historic opportunity not just to make some changes but to "get it right," to craft a health care system that will provide financial and health security for all Americans. They view health care as a right. They believe the federal government must play an integral role in solving the crisis. They think limits must be set on physician and hospital charges. They want to break the link between employment and health coverage. And they are deeply troubled that the private insurance companies are often the primary health care decisionmakers.

Our experience parallels much of the polling data. For instance, the recent Kaiser/Commonwealth Health Insurance Survey found that 39 of the people worry that their insurance company will not pay large medical bills, 60% want government to play the primary role in providing health insurance and controlling costs, and over 70% want rates set for doctors, hospitals and prescription drugs.

At the same time that Americans are expressing more fear about their health care future, they are being inundated by a multi-million dollar advertising campaign by the private health insurance industry complete with polls, print and television ads, and 1–800 numbers. Unfortunately, neither the polling efforts or the ad campaigns address many of the most common concerns expressed by people around the country. For example, the Health Insurance Association of America-financed poll, in asking people to select between pay-or-play, single-payer or insurance-based approaches did not address the questions of levels of cost-sharing, benefit limits, freedom of choice of providers, or the role of the insurance industry in denying or approving claims. Citizen Action has found that support for any approach changes dramatically based on the answers to those questions.

The insurance industry's well-financed campaign presents both a distorted view of national health insurance and a distorted view of our nation's experience with a reliance on private coverage. Missing from their ads, for example, is the evidence that Canadians are the most satisfied with their health care system and Americans among the least satisfied. Fortunately, the efforts of the insurance industry have been offset by the work of health care coalitions around the country which are more accurately describing the actual costs, benefits and problems associated with health care reform proposals.

PREPARED STATEMENT OF RICHARD J. DAVIDSON

Mr. Chairman, I am Dick Davidson, president off the American Hospital Association (AHA). On behalf off the AHA's nearly 5,400 member hospitals, I appreciate the opportunity to share with you our vision for reinventing our health care delivery system.

We understand that the task before this Committee is a difficult one. Current budget constraints force difficult choices among competing needs. But if we resort to purely budget-driven decisions, we will only be fueling the crisis in our health care system, not taking steps toward solutions. And ultimately we will not solve the problems the American people are making it clear they want us to address.

The time is past when we can treat symptoms and ignore underlying causes. It's time to junk the policies of the past, overhaul the health delivery structure, and encourage different behaviors by consumers, providers, and payers. Only in that way will we achieve access for all to needed services at a cost this country, employers, and citizens can afford. It is clear to all of us that dramatic change must and will occur. I come to you today to share a better idea for health reform.

THE AHA REFORM PLAN

Hospitals believe the future of health care in this country is at a critical juncture. Our financing system has created conflicting incentives for patients and providers and our delivery system does not reach many in need of care. The current health reform debate addresses two competing and probably conflicting challenges: expand access and contain costs. The challenge is to find an acceptable balance between providing more access to health care services while at the same time conserving health care resources and dollars. We think we've got a solid idea for meeting both these goals.

AHA's plan is a comprehensive approach to health care reform: everyone would have access to basic health benefits; costs would be contained through economic self-discipline by all participants as opposed to burdensome federal regulation; and a restructured delivery system would focus on community need and encourage providers to form efficient networks at the local level.

Universal Access

Everyone must have access, at a minimum, to basic health care benefits. AHA seeks a comprehensive basic benefits package covering the full range of services from preventive care through long-term care. Health promotion and preventive care services would be emphasized.

AHA's proposal achieves universal access to basic health care services, through a pluralistic system of financing—a combination of private insurance and a new single public program consolidating and expanding Medicare and Medicaid. Catastrophic coverage would be provided under the public program for everyone, whether covered by the public program or by private insurance in order to guarantee that no one would be impoverished by their need for health care.

Access for all would be assured by building on the current employer-based private health insurance system. Employers would either provide coverage for their workers or pay the premiums necessary to enroll them in a publicly operated program. AHA supports this approach because we believe it is the most realistic way to get the uninsured—most of whom are employed or workforce connected—insured. It must be remembered that 88 percent of the non-elderly privately insured population is covered through employer-based groups.

This support also is contingent on the critical need to put affordable health insurance within the reach of all businesses, particularly small ones. For that reason, the premium payment requirement would be phased in, in concert with enactment of insurance market reforms enabling more working Americans access to reasonably priced insurance. AHA is proposing insurance reform and tax incentives for both employers and employees.

COMMUNITY CARE NETWORKS

Virtually all the health reform proposals now before the Congress stress cost containment through regulation, by imposing aggregate expenditure targets or setting provider payment rates. Some propose to hold costs down through competition, by encouraging expansion of price-driven competitive models.

All of these approaches are fundamentally flawed because they seek cost containment without addressing the underlying problems in our system that have led us to our present predicament—fragmentation of care and skewed incentives.

Whatever savings these approaches may generate will be short-term and very limited. But the long-term cost to the stability and quality of our health care system will be great.

The AHA has taken a strong position on responsible and effective cost containment. We believe economic discipline can be achieved only by restructuring health care delivery. The focus of this restructuring is our concept of community care net-

works that would realign incentives and encourage the efficient use of health care resources by everyone.

At the heart of this concept is a simple, fundamental principle: health care is a local concern. People live and work in their communities. When they get sick, they generally want to seek health care services near their home and families.

Community care networks would give patients access to integrated care organized at the community level. Networks would be responsible for all the health care needs of their enrolled population and would coordinate patient care over time and across various provider settings—everything from preventive care to acute care to long-term care services.

ECONOMIC DISCIPLINE

How would a community care network contain costs? The key to community care networks and to cost containment within this system is risk-adjusted capitated payments to the networks. Capitation—a set fee paid to the network per enrollee—would form the network budget for delivering care to the enrolled community. Payers could manage spending1 but the allocation of resources would be a local decision. Thus providers would have an incentive to:

- Promote the health off enrollees and prevent future, more costly illnesses. It is in the network's own financial interest to provide their enrolled population with more efficient preventive care now in order to avoid the use of more costly acute care later.
- Collaborate with other providers to avoid duplication of services. Once hospitals, physicians, and others are linked within a network, their incentive would be to avoid future duplication of technology, services and facilities. Community care networks would move the concept of competition away from the medical arms race to a level based on service to patients.
- Conserve health care resources and dollars by providing only appropriate and necessary care. The collective challenge to providers within networks will be to provide needed health care services within the fixed capitation amount through better patient care management by practitioners and institutions.

How would the concept emerge from today's complex federal budget system? Congress would set a budget for the public program—Medicare and Medicaid combined. Based on this budget, an independent, public body at the federal level would then define the basic set of benefits to be covered by the public plan. This set of benefits also could serve as the basic standard for coverage offered by private insurance plans. The independent body, or possibly even a state-level entity, would set the capitated rates to networks, adjusting those rates to reflect the underlying risk of the population covered and the geographic conditions under which services are delivered. In this way, network financing decisions would be removed from the political and budgetary process, and health care costs and benefits can be more fairly balanced.

AHA believes the federal government could encourage formation of community care networks in a very powerful way by instituting Medicare and Medicaid program use of networks and by providing financial incentives for beneficiaries to choose networks. In the private sector, tax or other incentives aimed at employers, employees, insurers, and providers could help make delivery system reform of this kind a reality very quickly.

IMPROVED PATIENT CARE

Would community care networks improve patient care? Yes, because they hold the promise for truly managing care—not just costs. Many of the "managed care" arrangements today are simply insurer programs that contract with a selected group of providers for discounted prices. Participating providers in the plan change frequently as insurers shop around each year for deeper price discounts—discounts seldom linked to efficiency or better care. Access to those providers is then controlled by insurers who require authorizations before anyone can receive non-emergency care. This emphasizes managing costs, but does nothing to measure that the patient is getting the right care at the right time for the right reasons.

Managing care in the patient's interest means assessing their health risks, lifestyle, and needs, and planning and organizing care so that problems are averted or treated early and all needed services are efficiently provided. Within community care networks, each enrollee would be matched with a primary caregiver to ensure a consistent, specified point of entry into the network. The primary caregiver's responsibility would be to make certain that an initial evaluation of health status is conducted, that appropriate primary care and preventive services are planned and

delivered, and that services throughout the system are coordinated for the patient, particularly when specialty services are needed.

Making community care networks a reality will require a series of reforms aimed at improving the climate for appropriate cost conscious behavior:

- tort reform to reduce the cost of the malpractice system and its effect of stimulating defensive medicine;
- anti-trust and other legislative reforms to allow the type of collaboration needed to make the best use of available resources;
- and greater development of medical practice parameters to foster effective clinical decision making.

Community care networks are the keystone to universal access. They represent a self-disciplining system with coherent and consistent incentives that encourage providers to do what they do best—manage the health care of their patients. On this score, other health reform proposals don't measure up.

LIMITS ON HEALTH CARE SPENDING

Despite the large number and variety of reform proposals before the Congress, the cost containment approaches are quite similar. Several of the major proposals rely on a structured, top-down regulatory approach to cost containment. That is, they call for setting a single, national health expenditure target and then allocation of that fixed pot of dollars in various ways among various health care providers through global budgeting or rate setting.

But if we focus our cost containment effort on simply capping how much we spend won1t w: succeed only in perpetuating many of the current flaws in our system? Won't merely setting expenditure targets for each sector of the health care economy set in amber the confusing, fragmented way patients get care now? Shouldn't we be moving toward more coordinated and better managed care? Why perpetuate conflicting incentives that are a root cause of unnecessary duplication and waste and have brought on the very mess we're trying to fix?

More troubling is the collision course we set if we cap spending at current levels and at the same time expand access to millions. The experience with Medicare and Medicaid payment policy shows the impact of simply capping spending. The result is that the Medicare program pays hospitals about 10 percent less than their costs, and hospitals on average get about 75 cents on the dollar for services to Medicaid patients. One lesson is that any cost-containment mechanism needs to be flexible enough to accommodate increased spending due to changes in the size or age of the population served, expanded benefits, changes in the needs of the population, and changes in utilization that result from the continuing evolution of health care technology and delivery.

Expenditure caps are very simple way to control *spending* by payers, but they fail to reach and restrain health *costs* experienced by providers. Limiting the total dollars that are made available for health services without somehow changing the underlying incentives for providing and using health care services is just one more budget-driven quick fix destined to fail.

The very provider behavior that today is so troubling is the result off reliance on constraining program spending as the chief agent of cost containment. High quality patient care and a rational distribution of resources should be the goal of cost containment policy, not a hoped-for byproduct.

Many of the reform options before the Congress would impose a arbitrary expenditure caps on all purchasers of health care. We are concerned that if indeed Medicare is the role model some would emulate, all patients and all hospitals would suffer. It would amount to letting the federal government underpay for everyone, not just the poor, elderly, and disabled. AHA projects that in 1992, Medicare PPS payments to hospitals will be 90 percent of hospitals' Medicare inpatient costs. By extending Medicare inpatient payment levels to all payers, PPS hospitals would be paid about $19 billion less than their costs in 1992—yielding a reduction in the nationwide average total hospital margin from positive 3.5 percent to *negative* 5.7 percent, according to the Prospective Payment Assessment Commission.

Underpayment is not cost containment. Top-down regulatory limits on provider payment do not address the root causes of health care cost increases. More importantly, they do not address the changes needed in our system to improve patient care. If the result of reform isn't more coordinated and better managed patient care, we all will have failed the American people miserably.

Government rate setting requires trust and confidence in the federal government to keep its promises to adequately fund whatever program it creates. The federal government has not kept its promise to adequately fund Medicare. As long as health

care financing is subject to annual budget battles, there's little reason to believe government will try to keep its end of the bargain on an even larger scale.

CONCLUSION

Mr. Chairman, I understand the difficulties you and the Congress face in achieving fairness when resources are limited. AHA wants to be part of a far-reaching solution that not only looks to widen access and contain costs, but holds out the promise of better care for patients in the bargain. We look forward to working with this Committee as you shape health reform for this country.

PREPARED STATEMENT OF KAREN DAVIS

Thank you, Mr. Chairman, for this opportunity to testify on comprehensive health care reform. The U.S. is the only industrialized country which does not provide access to health care for all of its citizens. Over the past century, there have been many public debates on the need for a universal health system, and some of these debates resulted in important incremental reforms, such as the 1965 passage of Medicare and Medicaid. In the 1990s, there is a growing consensus that our health care system is in critical condition and that the time is ripe for comprehensive reform.

Today I will address the major problems facing the U.S. health care system, that of health insurance coverage and the high and rising costs of health care services. I will then describe the Administration's proposal for reform through tax credits and deductions and changes in the health insurance market. In contrast, I will describe three types of comprehensive reform proposals introduced into the 102nd Congress. Finally, I will assess the impact of the comprehensive proposals on health insurance coverage and cost, comparing and contrasting these effects with the current Administration's approach.

HEALTH INSURANCE COVERAGE

The major problems facing the U.S. health care system are the deterioration of financial access to services and the rising costs of providing those services. Typically in the U.S., financial access to services is achieved either through health insurance provided by one's employer, or through a public insurance program; but a staggering 34 million Americans lack coverage by either private or public sources. While differences in survey methodology make it difficult to measure changes in the uninsured population over time, it is clear that the number of uninsured has grown significantly in the past 10 years.

The majority of Americans, 152 million, have employer-based insurance. Another 15 million Americans are covered under individual health insurance plans, paying high premiums and often receiving limited benefits. Public health insurance, provided through Medicare and Medicaid, covers 48 million Americans. while these public programs have had a significant impact on the health status of the poor and Americans over age 65, restrictions in eligibility have limited Medicaid's coverage to only 40 percent of the poverty population.

The profile of the uninsured has become all too familiar to policy makers. In two thirds of the cases, the uninsured are from working families where someone works full-time. Another 13 percent are working part-time. It is important to recognize that only 20 percent of the uninsured are not working, including the unemployed, the disabled who have not met the two-year waiting period for Medicare, and those who have had to retire before age 65 but do not have employer-provided health benefits.

The nature of employment is an important predictor of insurance coverage. In certain occupations, in part-time or seasonal work, and in smaller firms, workers are less likely to be covered by health insurance. Thirty-six percent of the working uninsured are in firms with under 25 employees and another 14 percent are self-employed. Small firms are in a difficult position because they face higher health insurance premiums than larger firms.

In general, the uninsured are not poor, but have incomes above the poverty level. Most of the uninsured are from middle class families with modest incomes. Only a small fraction, less than 10 percent, have family incomes above $50,000.

Other characteristics of the uninsured relate to age and gender. Men are more likely than women to be uninsured. The uninsured are often between 19 and 24 years of age. Children younger than age 18 are next most likely to lack coverage. Fifteen percent of American children under age 18 are uninsured. There are also a disproportionate number of racial and ethnic minorities among the uninsured.

while 19 percent of whites are uninsured, 30 percent of blacks and 41 percent of Hispanic Americans are uninsured.

The consequences of being uninsured are serious. The uninsured are less likely to have a usual source of care. They use fewer ambulatory and hospital services than insured persons in similar health, and they are more likely to report needing medical help they were unable to obtain. Often the uninsured delay seeking care, leading to more serious illness and avoidable hospital admission.

Having health insurance coverage does not automatically guarantee financial access to health care services. Copayments and deductibles are high in both Medicare and private health insurance plans. Those covered under public plans pay 19 percent of their expenses out-of-pocket for deductibles and coinsurance or for purchasing prescription drugs. Individuals covered under employer plans pay 27 percent of health expenses out-of-pocket. while those covered under individually-purchased private health insurance still pay 40 percent of their medical bills directly.

Finally, health insurance coverage does not assure that services will be available, especially in underserved areas.

HEALTH CARE COSTS

The second major problem with the U.S. health care system is the high and growing cost of providing services. In 1990, health expenditures consumed 12.2 percent of the Gross National Product (GNP), up from 6 percent in 1965. By the end of this decade, health expenses will account for 21 percent of GNP—almost $2 trillion.

On a per capita basis, health expenditures averaged $2,678 in 1990, up from $204 per person in 1965. By the year 2000, it is estimated that health expenses will reach nearly $7,000 per person. These sums are staggering. They pose real financial burdens on families, businesses and taxpayers.

Rising health care costs are a serious threat to the U.S. economy and its future competitiveness. Rising health insurance premiums are consuming workers' wages and imposing a growing burden on American businesses. They are a major cause of strikes in the U.S. tile today; health insurance premiums are 12 percent of payroll expenses; by the year 2000, this will increase to 23 percent.

Compared with other similar industrialized countries, the U.S. spends far more on health care. In 1990, the U.S. spent 12.4 percent of its Gross Domestic Product on health care. Canada spent only 9 percent, Germany 8.1 percent and Japan 6.5 percent.

On a per capita basis, the U.S. spends 43 percent more on health care than Canada, twice as much as Germany, and 131 percent more than Japan.

Why is there such a disparity between the U.S. and these similar, industrialized countries? One obvious reason is that Canada, Germany and Japan each have national health systems with strong cost control mechanisms. when one looks at the various components of cost, the differences in cost control become even clearer.

In the U.S., the components which drive the health care costs are high physician fees and hospital costs, as well as high administrative costs. According to one study, U.S. physician fees are 2.6 times as high as in Canada.

Administrative costs are also substantially higher in the U.S. than in other countries. For small firms, administrative costs average 34 percent. In more medium size firms (500 employees), 12 percent of health insurance spending goes for administration. This contrasts with 2.3 percent of Medicare outlays going for administrative expenses. In Canada, administrative costs are only 1.4 percent of outlays.

BUSH ADMINISTRATION'S HEALTH CARE PLAN

In response to the crisis in our health care system, the Bush Administration has proposed a plan which is market-based, providing financial incentives (tax credits and tax deductions) for the uninsured to purchase health insurance and reforming the insurance market so that insurance is more affordable and available.

Health Insurance Networks (HIN) would be fostered to allow the group purchasing of health insurance by small businesses. This would help small businesses negotiate discounts and save on overhead and marketing costs.

The Administration proposes that cost control would be realized through major malpractice reform and encouraging the use of coordinated care or managed care plans. Administrative savings would also be achieved through electronic billing for providers, electronic benefit cards for policyholders, simplified utilization review and insurance market reforms.

OPTIONS FOR COMPREHENSIVE HEALTH CARE REFORM

In the 102nd Congress, numerous legislative proposals have been introduced which would take a comprehensive approach to health care reform. I would like to

comment on three of these approaches, employment-based coverage, expansion of the Medicare program, and the single payer system.

The employment-based coverage plan, or "play or pay," as it is commonly known, would achieve universal health insurance coverage by requiring all employers to either provide private health insurance coverage to workers and dependents or pay a payroll tax to cover them under a public plan similar to Medicare. Anyone not covered under the employer plan, such as the unemployed, newly disabled, early retirees, or the poor, would be automatically covered under the public plan. The Medicaid program would be replaced by the public plan as well.

The public plan would establish a minimum benefit package, including basic benefits such as hospital and physician services with some cost-sharing, preventive services such as well-child care and would set a maximum ceiling on family out-of-pocket expenses for health care.

Employment-based proposals differ with regard to cost control, but generally the approach would use Medicare's hospital and physician payment methods as a basis for an all-payer system with expenditure targets. In other words, physicians would be paid the same fee for caring for a privately insured patient as for a poor patient or a Medicare patient.

The sale of private health insurance to small business would be regulated to prohibit excluding individuals with bad risks or charging higher premiums to groups with bad risks.

The play or pay plan would achieve administrative savings through a single system of provider payment, uniform claims and electronic billing.

Financing would come from a combination of employer/employee premiums to private health insurance and tax revenues.

A second comprehensive approach, "Medicare for all," would extend the current Medicare program to everyone, and enrollment would be automatic at birth. Benefits would be improved to cover preventive services especially for pregnant women and children, and a maximum family deductible of $500 and a ceiling on out-of-pocket expenses would be established. Some individuals or families might choose to supplement Medicare coverage with private coverage.

Since there would be only one major system of health insurance, providers would be paid the same way for all patients, through DRG prospective payment for hospital services and Medicare's fee schedule for physician services.

Administrative savings in this type of plan would be achieved by building on the low administrative costs in Medicare. Benefits would be financed by tax revenues paid by employers and families.

The final type of comprehensive approach, often referred to as the "single payer" plan would establish a single comprehensive public plan for the entire population. This plan would provide comprehensive benefits, typically including prescription drugs and possibly long term care, with no patient cost sharing. Cost controls would be enforced through establishment of global budgets or expenditure ceilings and a single system of paying providers. Depending upon the type of plan, providers could be paid fee-for-service or salaried.

Administrative savings would be achieved through one-time enrollment at birth, the elimination of tracking and collecting cost-sharing from patients and a single simplified system of provider payment. The plan would be financed by tax revenues, probably with new tax sources.

ANALYSIS OF COMPREHENSIVE HEALTH REFORM OPTIONS

A comparison of these plans indicates that three of the plans, the employment-based coverage plan, Medicare expansion, and the single payer system, would address the issue of access directly, whereas the Administration's plan would leave many people uninsured. bile the comprehensive proposals would provide universal health insurance coverage and comprehensive benefits, a tax incentive and market reform approach would not significantly improve coverage or assure adequate benefits.

Most of the comprehensive proposals as well as the Administration's plan address the development and support of community-based primary care systems which helps assure the availability of health services in underserved areas.

In terms of cost control, each of the three comprehensive proposals could reduce the growth in health care expenditures over the next 10 years to the rate of growth of the GNP. If the plans phased in cost controls gradually, total health spending in the year 2000 would be $1.6 trillion rather than $2 trillion. If the growth in health outlays were immediately reduced to growth in GNP, health outlays would be $1.3 trillion in the year 2000.

All three comprehensive plans would substantially reduce administrative costs in the current system. Administrative costs currently average 18 percent (including 40 percent on individual policies and 2 percent on public plans). This would be reduced to 1 to 6 percent under the three plans.

It is important to recognize that although the three comprehensive plans would require new taxes to finance, total health spending would be lower than under the current system. By the year 2000, all three plans with phased-in cost controls would cost $1.6 trillion in total health outlays. The federal share of the cost, however, could range from 36 percent in the play or pay plan to 67 percent in the Medicare for all plan, and 85 percent in the single payer plan.

The cost control provision of the Administration's proposal relies heavily on voluntary enrollment in managed care and individual behavior change such as the use of preventive services as well as malpractice reform. The administrative savings would be achieved through electronic billing, but would be offset by new administrative costs as more people applied for high cost individual private insurance.

In summary, the employment-based coverage, Medicare for all and the single payer plan would achieve the basic goals of universal coverage, comprehensive benefits, administrative savings and a reduction in health care expenditures. The single payer plan provides better financial protection and somewhat greater administrative savings, but also requires relatively greater tax increases to finance. The employment-based coverage plan minimizes the change in private health insurance coverage, but has somewhat more regressive premium financing. The Medicare for all plan would replicate some of the current experience with Medicare, that is, lower administrative costs and controls on hospital and physician spending. While the Administration's proposal might achieve some administrative savings, it would not have an appreciable effect on access to care or overall health care costs.

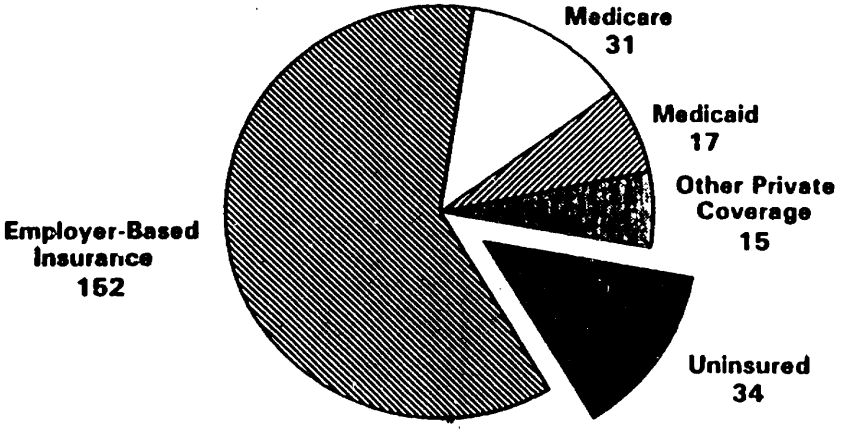
Thank you for this opportunity to comment.

Attachment.

APPENDIX—COMPREHENSIVE HEALTH CARE REFORM CHARTS

CHART 1

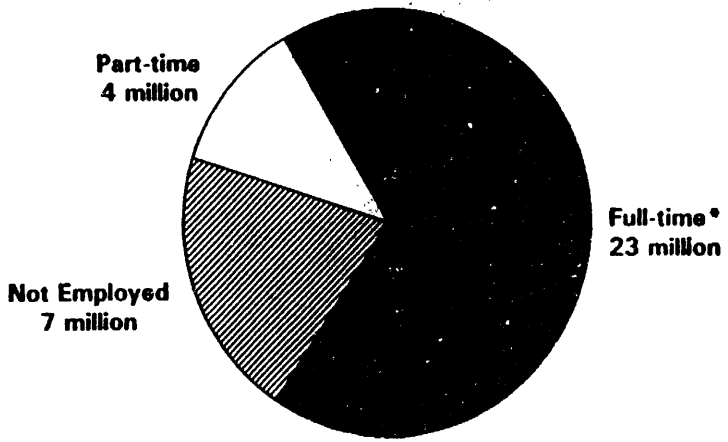
34 Million Americans Were Without Health Insurance in 1991



Population by Source of Health Insurance (in millions)

Source: Karen Davis, Johns Hopkins University, 1992

The Majority of Uninsured Americans Are Employed Full-Time



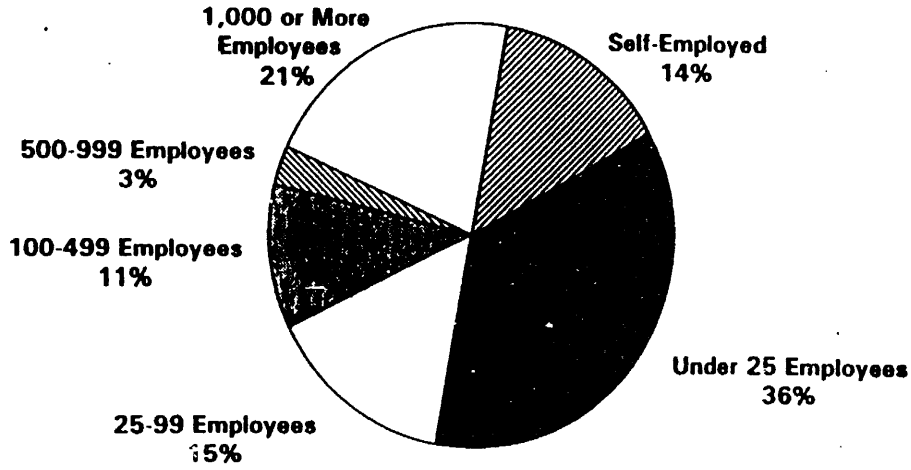
Uninsured by Employment Status, 1990
(34 million)

Source: Karen Davis
Johns Hopkins University, 1992

*Full-time = 35 hours per week

CHART 2

Smaller Firms are Less Likely to Provide Health Insurance

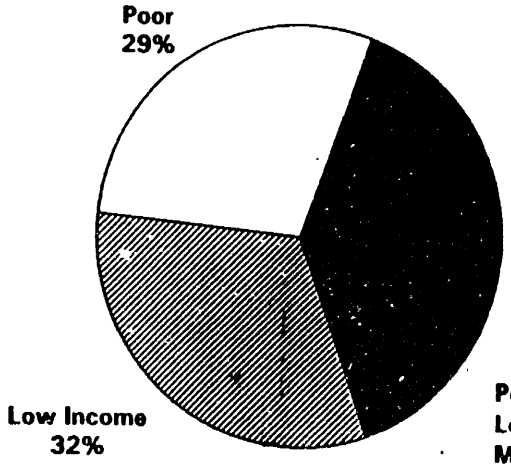


Distribution of Uninsured Workers by Size of Firm, 1990

Source: EBRI, based on 1990 CPS

CHART 3

Two-Thirds of the Uninsured Are Above the Federal Poverty Level*



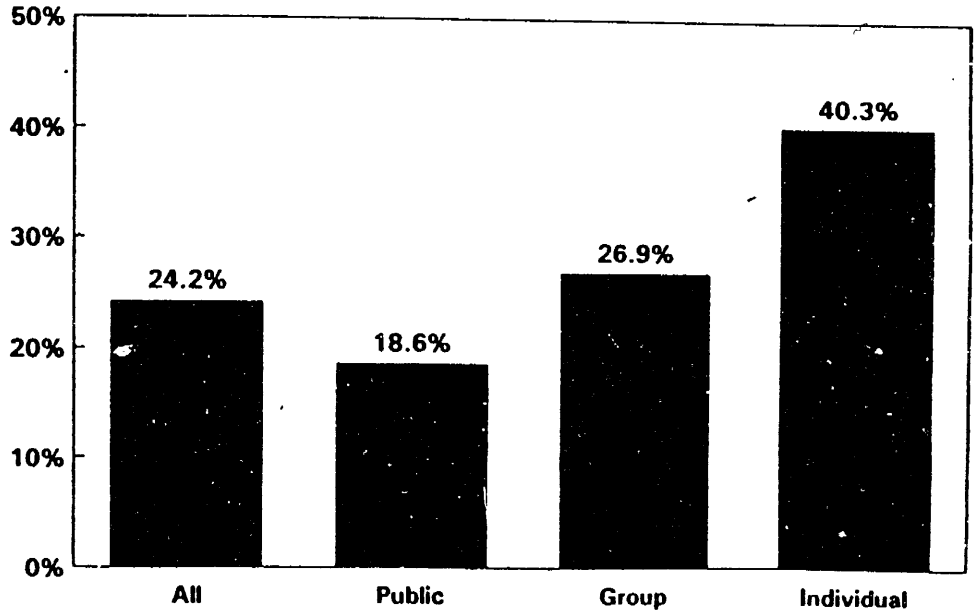
Uninsured by Income, 1990

Source: Karen Davis
Johns Hopkins University, 1992

*Federal poverty level for a family of four in 1990 was $13,360

CHART 4

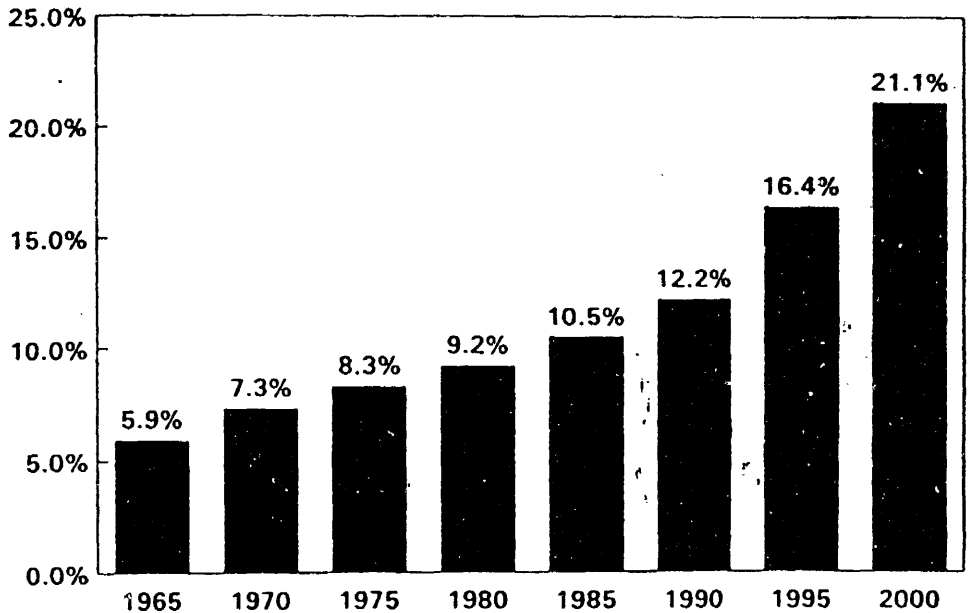
Percent Out-of-Pocket Expenses by Type of Insurance Coverage, 1987



Source: Karen Davis,
Johns Hopkins University, 1992

CHART 5

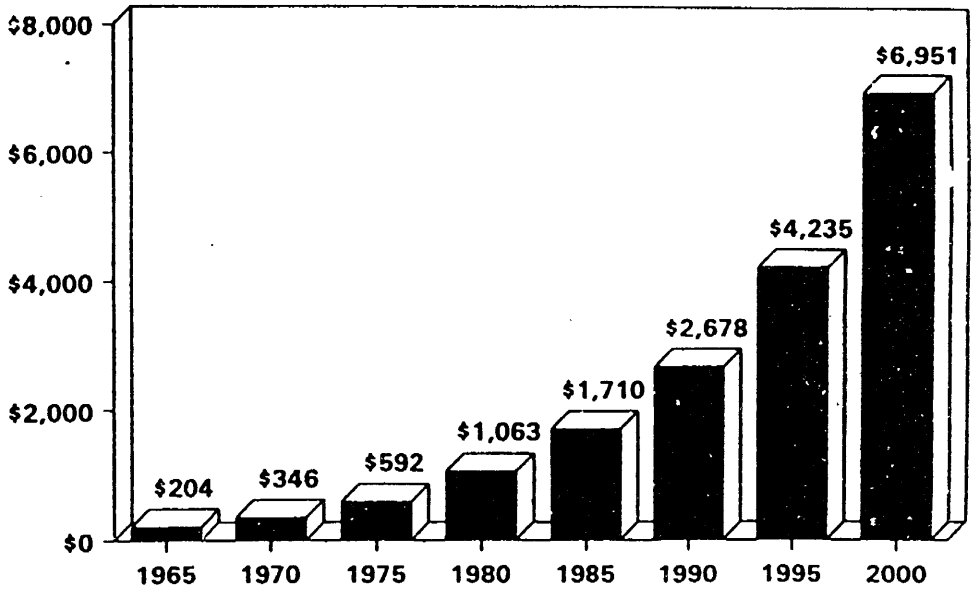
Health Expenditure as a Percent of GNP
1965-2000



Source: Karen Davis,
Johns Hopkins University, 1992

CHART 6

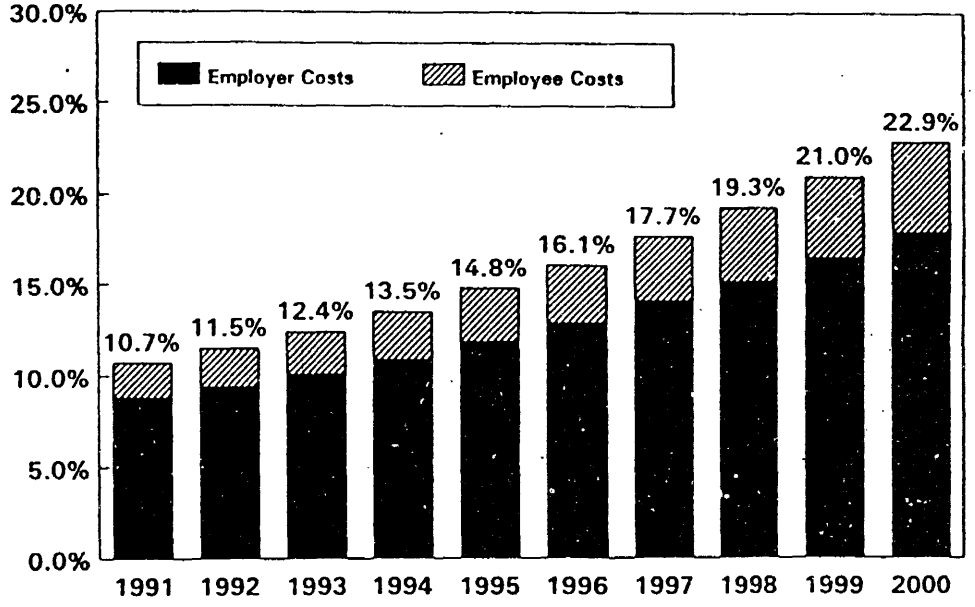
Per Capita Health Expenditures Are Rising Rapidly



Source: Karen Davis,
Johns Hopkins University, 1992

CHART 7

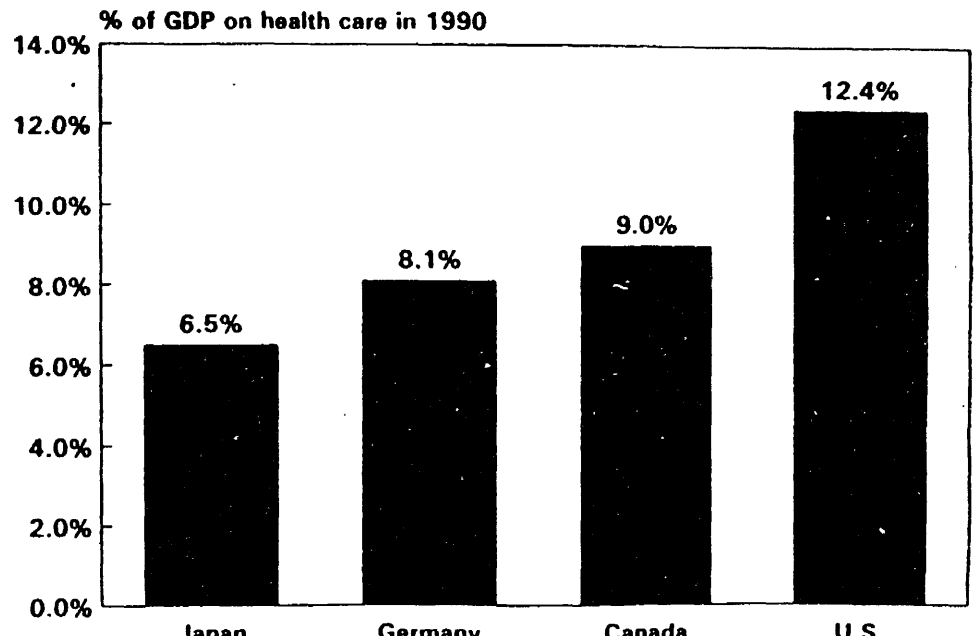
Health Insurance Premiums as a Percent of Payroll are Rising



Source: Karen Davis,
Johns Hopkins University, 1992

CHART 8

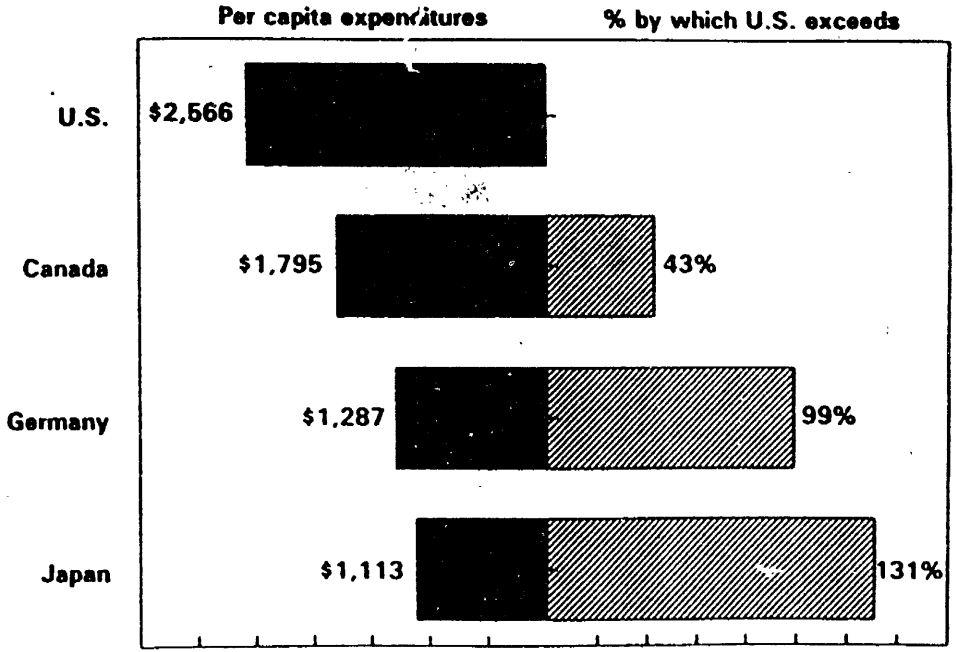
The U.S. Spends More on Health Care Than Any Other Country



Source: OECD, 1991

CHART 9

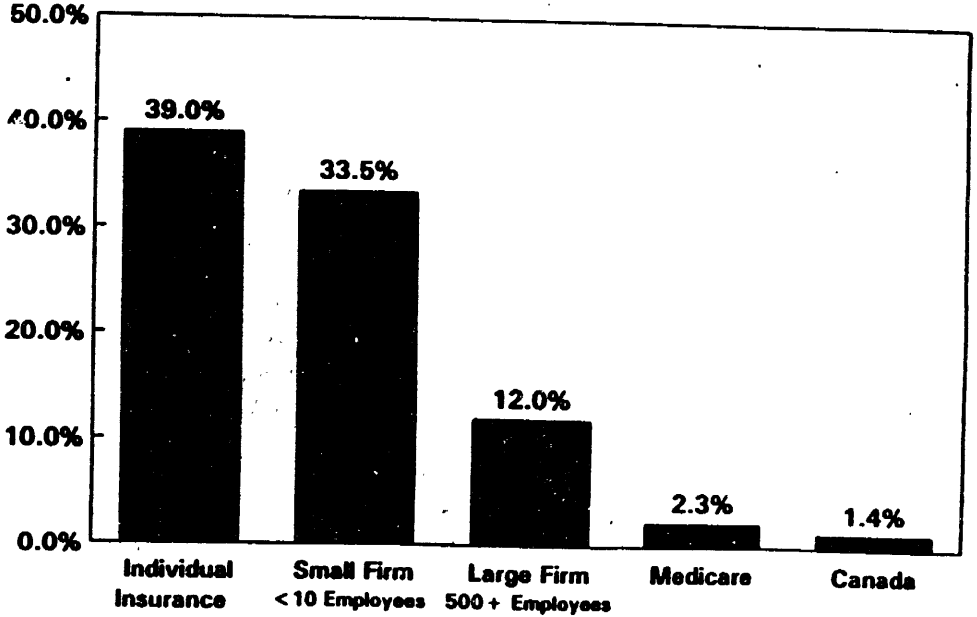
Per Capita Health Spending in Selected Countries, 1990



Source: OECD, 1991

CHART 10

Administrative Expenses as a Percent of Health Benefits, 1987



Source: Karen Davis,
Johns Hopkins University, 1992

CHART 11

CHART 12

PRESIDENT BUSH'S HEALTH PLAN
TAX CREDIT/MARKET REFORM

- Tax credit ($3,750) to defray the cost of health insurance for those below poverty
- Tax deduction (up to $3,750) to defray the cost of health insurance for families with incomes below $80,000
- Market reform
  - Basic benefit package
  - Elimination of preexisting condition limits
  - Health Insurance Networks
- Malpractice reform
- Coordinated care or managed care systems
- Administrative streamlining

CHART 13

EMPLOYMENT-BASED COVERAGE

- Universal Coverage
  - -- Employer choice of private health coverage or paying a payroll tax for public plan coverage
  - -- Everyone else automatically covered under public plan
- Basic benefits with cost-sharing, preventive services, and ceiling on patient out-of-pocket expenses
- All payer provider payment and expenditure targets
- Small group insurance market reform
- Administrative simplification
- Financed by employer/employee premiums and tax revenues

CHART 14

MEDICARE FOR ALL

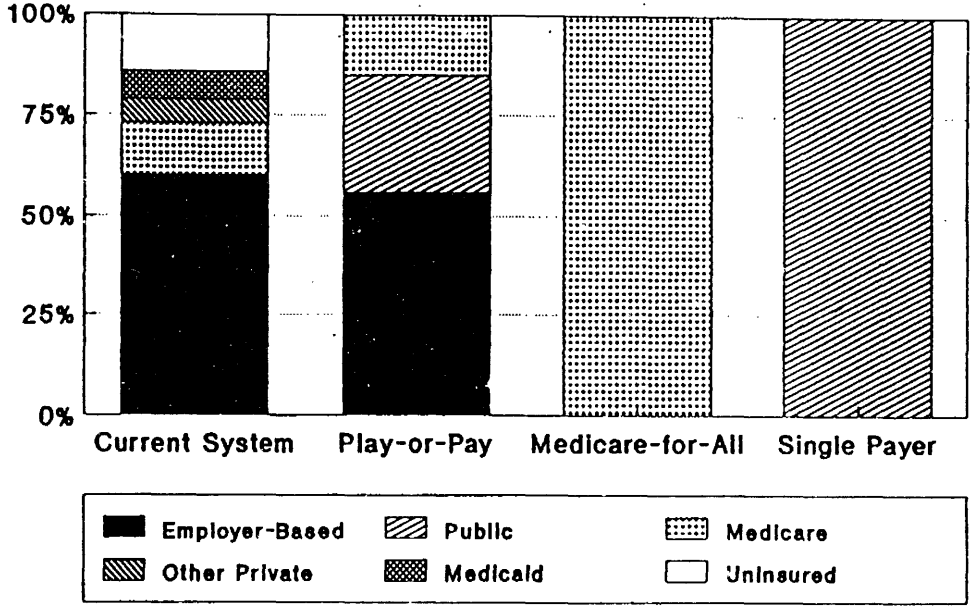
- Medicare coverage extended to entire population; benefits improved to cover prevention especially for pregnant women and children
- Medicare provider payment methods apply to care of all patients
- Medicare low administrative costs extended to all
- Financed by tax revenues

CHART 15

SINGLE PAYER PLAN

- Comprehensive benefits provided under a single public plan without cost-sharing
- Cost controls through global budgets or expenditure ceilings
- Administrative savings through single payment system and no private health insurance
- Financed by tax revenues

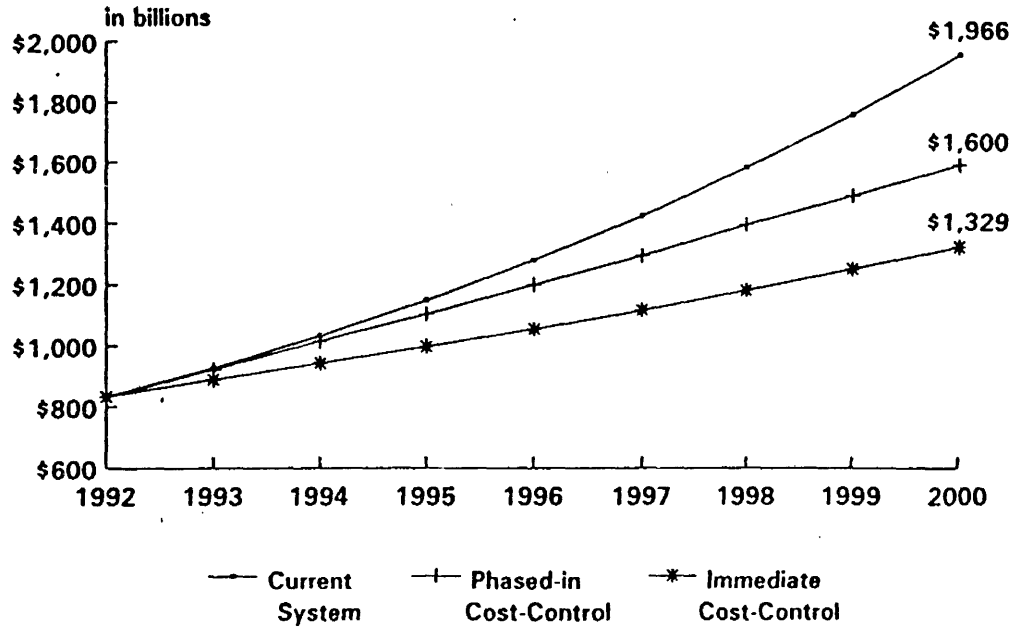
Source of Health Insurance Coverage Under Health Care Reform Options



Source: Karen Davis,
Johns Hopkins University, 1992

CHART 16

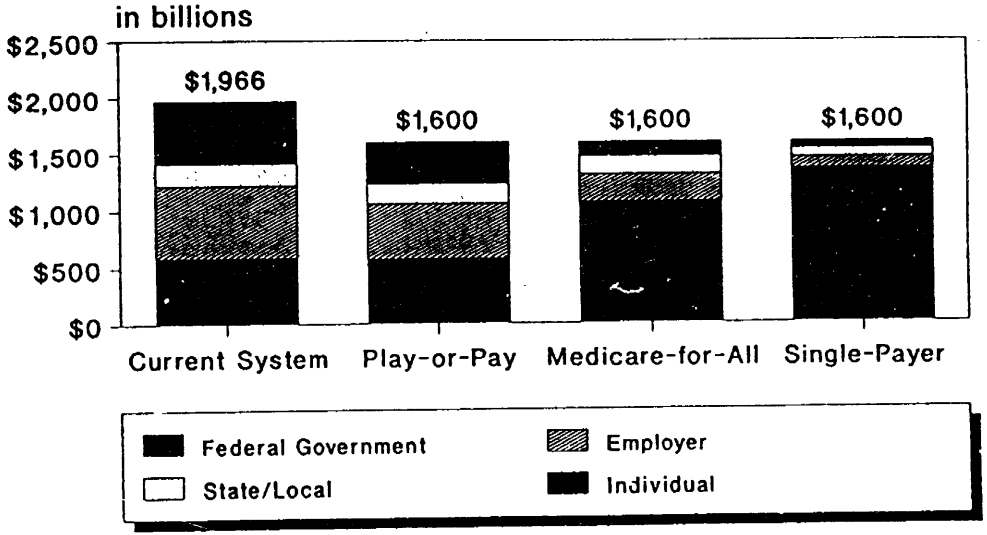
Projected National Health Expenditures Estimated for 1992-2000



Source: Karen Davis,
Johns Hopkins University, 1992

CHART 17

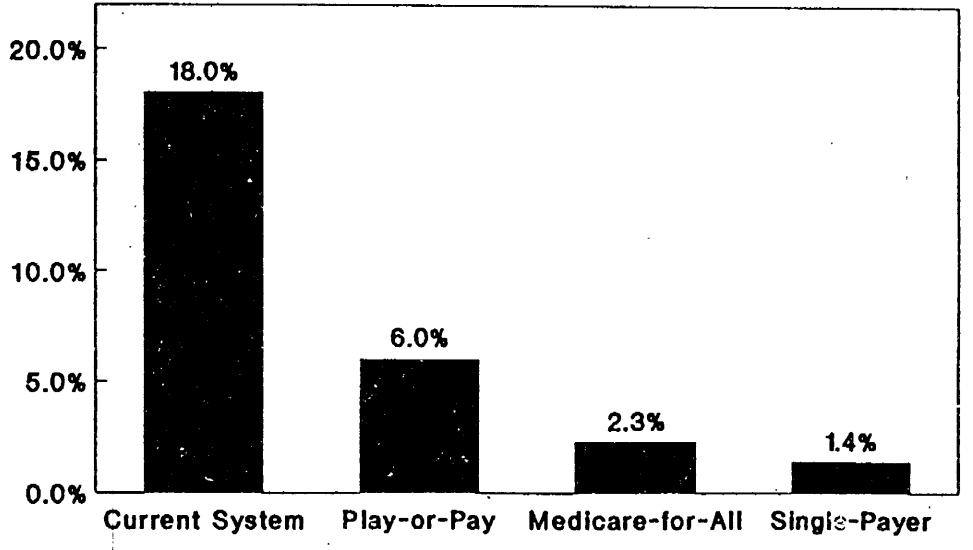
Summary of Health Care Reform Proposal
By Source of Financing
Estimated Total Expenditures, 2000



Source: Karen Davis,
Johns Hopkins University, 1992

CHART 18

Percent of Health Expenditures for Administrative Costs Under Health Care Reform Options



Source: Karen Davis,
Johns Hopkins University, 1992

CHART 19

SUMMARY OF HEALTH CARE REFORM PROPOSALS

	Employment Based Coverage	Medicare Expansion	Single Payer	Tax Credit/ Market Reform
Coverage	Universal	Universal	Universal	Remaining Uninsured
Benefits	o Hospital and physician services o Preventive package	o Hospital and physician services o Preventive package	o All medically necessary services	o Limited
Major Cost Control Mechanisms	o All payer system with expenditure targets	o Prospective payment for hospital services o Fee schedule for physician services	o Global budgets or expenditure ceilings o Single payment system	o Managed care o Malpractice reform
Administrative Savings	Yes	Yes	Yes	Minor
Effect on Current Health Care Spending	Substantial Reduction	Substantial Reduction	Major Reduction	Minimal or No Effect

CHART 20

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

The Finance Committee has been facing the challenge of health care reform for years. The good news is that reform is now on the national agenda. The American public is looking to us for action.

However, this national spotlight is bright, and it highlights the differences among us. These differences are reflected in the number of bills pending before this committee, 15 at last count and rising. It is also reflected in the views of the experts on the panel before us today. All of them have reputations for thoughtful analysis and I welcome their insights.

We can get overwhelmed by our differences, and by the complexities and the details of these proposals. After all, this is an 800 billion dollar system.

Despite our differences on solutions, I believe that we can take heart in the fact that we do have an emerging consensus on key goals. If we focus on the goals, we can better critique these various "comprehensive" solutions that are before us.

This is the goal as I understand it:

We all want universal access to superior quality care through universal coverage of financial risk.

In other words, we want MORE CARE for more people.

In our current budget climate, however have to PAY LESS. There is no need for me to reiterate the alarming escalation of costs in all sectors of health care and the ever-increasing budget deficit.

In my mind, while we may have 15 proposals, there are really only two ways to go to GET MORE FOR LESS:

We can turn it all over to the government to cut expenditures pure and simple;

OR, we can get more PRODUCTIVITY.

The first approach is one we know a lot about. We all know how government tries to reduce costs:

It will put limits on provider payments, limits on procedures and technology, reductions on new products, new procedures and new ideas. Eventually, there will be limits on services, rationing, and stagnation.

Furthermore, before we hand the system over to the government, with its big hand pressing down on the system, we should remember that we are not very good at cost reduction in this manner. Just look at Medicaid. The expenditures for this program are escalating out of control. We spent 70 billion on the program in 1990, and will spend an estimated $122 billion in 1992. HCFA estimates that we will spend 199 billion by 1995 at current rates. And, critics of the program abound.

We have another, and to my way of thinking, a clearly superior choice. We can choose productivity.

Productivity is simply getting a better product for less money. Productivity explains how we can produce increasingly powerful computers for increasingly lower costs. Productivity characterizes the genius of America and we have never applied that genius to the health care system.

How do we get productivity? We have to change the incentives to galvanize the five actors in the health care system—the providers, the insurers, the employers, the consumers and the government.

We have to change the way we practice medicine. This means more than simply paying less for endless numbers of procedures, but by systematically changing the structure, the organization, and the delivery of health care.

I know it can be done. We are doing it in Minnesota. We do it through competitive integrated systems that offer coordinated care. Many have abandoned the inefficient, bad incentives inherent in fee for service medicine.

We do it through vigilant employers who understanding how to purchase quality health care for less. We do it through better information for consumers and reasonable incentives to use the system wisely.

It does save money. When you look at the data from a recent Milliman and Robertson study of costs of group health insurance benefits in 400 largest metropolitan areas, Minnesota cities are far below average in the nation. For example, a similar insurance package in Duluth is 76% below the national average, while Los Angeles is 173% above the national average. Thats a difference of 97 percentage points for the same coverage!

The fact is that if everyone practiced medicine the way we do in Minnesota, we could take a couple of points off the GNP devoted to health, just like that. If all practiced the way the best 10% of providers practice, we wouldn't need massive reform.

And, even with Minnesota's favorable cost statistics there are still ways to save money without affecting the quality of care.

Take William McGuire, for example. Bill is the head of United HealthCare, an operation based in Minnesota that owns and manages HMOs and offers management services. He was the 15th highest paid executive in the United States—a salary of over 1 million and bonuses worth 7 million more. Why did he earn so much? Because he turned a profit of over 78 million dollars, doubled the equity in the company, and doubled returns to shareholders. How did he accomplish that? By saving his clients millions of dollars by identifying more efficient ways to deliver care! While I don't condone the size of his salary, I suggest that in Minnesota and elsewhere in the nation, substantial efficiencies and savings can be achieved without compromising quality care.

What I want to know from our assembled experts, is how we can get more productivity out of our current system, and how to do so in a timely fashion.

Where can we expect savings with changes in the practice of medicine? And, will those savings be static one-time savings or illustrate truly dynamic and continuing productivity.

I urge my colleagues not to opt for what appears to be a quick, painless solutions by government that will not work and will damage the best features of American health care. Efforts at productivity can get us to our goal of universal access to superior quality care faster, more efficiently, and with long-lasting results.

PREPARED STATEMENT OF ALAIN C. ENTHOVEN

Mr. Chairman, thank you for the opportunity to appear before this committee.

I have come here from California at my own personal expense. I am speaking on my own behalf as a concerned citizen and student of the health care system. I am not speaking on behalf of any organization or interest group.

The personal experience on which the judgments I offer is based includes Assistant Secretary of Defense; Medical Center Committee of the Board of Directors of Georgetown University; President of Litton Medical Products; Consultant to Kaiser Permanente; Consultant to Secretary Joseph Califano on National Health Insurance; and Stanford Professor where I teach courses on the Political Economy of Health Care in the United States, Analysis of Costs, Kisks and Benefits of Health Care, and Quality Management in Health Care; Chairman of the University Committee on Faculty/Staff Benefits at Stanford and Chairman of the Health Benefits Advisory Council of CALPERS that provides health coverage to 800,000 California public employees, retirees and dependents.

The points I would make in a brief statement are as follows:

1. Our nation's problems of health care cost and access are very large, complex, urgent and inter-related. They cry out for a thorough and comprehensive reform of our health care financing and delivery systems.

I will refer to market forces and competition. Some people use the rhetoric of free markets as code words for the status quo. Let there by no mistake. The status quo is untenable. I will be talking about fundamental, thorough and comprehensive reform of our system.

2. There is a great deal that can be done to improve health care quality and cut cost drastically by appropriately motivated comprehensive integrated health care financing and delivery systems that cannot be done by the disorganized traditional solo (or single specialty group) practice, fee-for-service, third party payment system that predominates today. (I will refer to the latter as "fee-for-service" for short.)

Integrated financing and delivery systems can:

- attract the loyalty, commitment and responsible participation of doctors;
- avoid costly adversary relationship between doctors and payors created by "fee-for-service;"
- align the incentives of doctors and the interests of patients in high quality economical care;
- ensure payment for good quality rather than the poor quality often favored by "fee-for-service;"
- organize to produce favorable outcomes efficiently;
- select doctors for quality and efficient practice patterns; offer educational support to keep them up-to-date;
- match numbers and types of doctors to the needs of the population served. Relative to fee-for-service, this means more primary care physicians to assure access; fewer specialists to assure the ones we have are busy and proficient;

- match other resources (beds, CT scanners, etc.) to needs; in fee-for-service we have many excesses: beds, open-heart surgery facilities, transplant facilities, etc;
- allocate all resources—capital and operating—efficiently across the total spectrum of care;
- implement Total Quality Management/Continuous Quality Improvement, the powerful management philosophy adopted by the winners in world market competition.

The RAND Corporation found that compared to fee-for-service in Seattle, Group Health Cooperative of Puget Sound cared for their patients in a randomized controlled trial for 28 percent less cost. I believe that if they had had serious competition and price-conscious buyers, Group Health could have done even better, much better.

3. What we must do is to move our health care system as fast as possible from fee-for-service to comprehensive integrated financing and delivery systems, publicly accountable for quality and cost, and with providers at risk for resource use so that they will be rewarded for finding and adopting less costly ways to care for their patients.

4. To date, so-called "competition" of integrated financing and delivery systems has not ameliorated our overall cost problem.

That is because, to date, in this country we have not tried economic competition.

In the economic realm, as opposed to the athletic, artistic, or political, and without further modification by another adjective such as "nonprice," "competition" means price competition.

There is much misunderstanding and misinformation on this point, but the plain fact is that with few exceptions such as the Federal Employees Health Benefits Program (FEHBP), we have not tried price competition in this country. And even the FEHBP has been poorly designed and managed from the point of view of creating price competition.

For there to be price competition, at least two conditions are necessary:

- If a supplier cuts price by a dollar, the person making the choice of supplier gets to keep the dollar if he chooses that supplier.
- The supplier must face an elastic demand curve; that is, if it lowers price it gains revenue. Otherwise it would always have an incentive to raise price.

Many features of the markets for health care financing and delivery plans conflict with these conditions. But they could be corrected by wise public and private purchaser policies.

- Most employers are committed to payment of all or most of the cost of a fee-for-service plan. Their policies do not allow the employee who chooses the most economical plan to keep the savings. Thus, they deprive the health plans any market reward for cutting price.
- The income and payroll tax laws have the effect that if the HMO to which I belong cut price by a dollar a month, it would only save me 60 cents a month net-after-tax. Thus, the marketplace reward it gets is only that which corresponds to a 60 cent price cut, about 60 percent of the increased membership it would get if we all paid the difference in price with after-tax dollars.
- There is a lack of comparative quality information that could reassure those considering a change based on price.
- This market is easy to segment by design of benefit package. Thus, a smart purchaser should standardize the benefit package.
- Small groups—say under 100—are usually too small to offer multiple competing health plans. An economical HMO can't capture their business unless a decisive majority agrees to require everyone to join the HMO. That greatly attenuates the volume response to price. Small groups should be pooled into large purchasing units that offer choice of plan at the individual level.

5. The only practical way to achieve a system made up of efficient integrated comprehensive financing and delivery organizations is through a strategy I call "managed competition."

The goal of this strategy is to reward with more subscribers those health care organizations that provide high quality care and control cost.

Competition must be managed to take away incentives to segment markets and select risks.

Managed competition assumes that everyone is covered through a Sponsor, (e.g., large employer, public agency or purchasing cooperative) that acts as a purchasing

agent, contracts with participating health plans, and actively manages a process of informed cost-conscious consumer choice.

The tactics of managed competition include:

- Qualification of the competitors; preselection of high quality cost-effective comprehensive care organizations to participate.
- Periodic open enrollment (no exclusions) managed by the sponsor.
- Defined employer contributions that do not exceed price of low-priced plans; cost-conscious employee choice.
- Risk-adjusted sponsor contributions.
- Standard benefit package.
- Informed consumers.
- Informed active management (e.g., monitor voluntary disenrollments, check out tertiary care arrangements.)

Market forces are the only forces known to man that systematically promote efficiency.

A system of managed competition would be compatible with American cultural preferences for pluralism and multiple competing approaches, individual choice and responsibility, and decentralized decision-making.

6. Now let me address the problems of small employment groups.

Roughly half the American employed population are in groups of 100 or less. Such groups (and even much larger ones) are too small to:

- spread risks;
- achieve economies of scale in administration;
- acquire needed information and expertise to function effectively in this market;
- offer multiple choice at the individual level;
- manage competition.

New institutions are needed to consolidate and empower the purchasing side of this market.

The health insurance industry (HIAA) has proposed the following reforms:

- All members of groups to be covered without individual exclusions;
- No pre-existing condition limitations for previously insured people;
- Guaranteed issue and renewability;
- Limits on rates and increases for individual groups relative to all groups;
- Voluntary reinsurance mechanism;
- Limits on pre-existing condition exclusions.

While these proposals appear superficially attractive, their implementation would be ineffective in solving the real problems of cost and access:

- The HIAA rules are compatible with 15-fold variations in premium among groups;
- They do not counteract market segmentation and product differentiation;
- They do nothing to lower high administrative costs in small groups;
- They do not open small groups to individual choice of health plan;
- This market is too complex and dynamic, and opportunities for evasion are too many and subtle, for effective supervision by a passive state regulatory agency.

7. Public policy regarding health insurance and health care are dominated by the supply side interests: medical associations, hospital associations, other health professionals, equipment and pharmaceutical manufacturers, insurance companies, and HMOs.

By comparison, the demand side in fragmented, confused, poorly informed and powerless.

To achieve a balance of countervailing power in the political and economic market places, we need to create strong demand side institutions whose mission is to represent the interests of consumers and payors, that can consolidate purchasing power, spread risk, achieve economies of scale in administration, and manage competition.

I propose the Health Insurance Purchasing Cooperative (HIPC), a purchasing agent for small employers.

In my mind, the inspiration for the HIPC is CALPEPS in which we cover 800,000 California public employees, retirees and dependents. We offer a choice that includes twenty-one HMOs and six PPOs, and, what is important for present purposes, we cover the employees of 700 local government agencies. This means, for example, that the two employees of the Antelope Valley Mosquito Abatement District get access to the same menu of plans at the same rates as state employees, which

rates are predicated on competition for a pool of 800,000 covered lives. And we run it for about $4 million a year, which comes to per person per year.

8. There are a lot of unanswered questions about the details of HIPCs, but here in broad outline is what is needed.

Each HIPC would be:

- a voluntary non-profit membership corporation whose board is made up of members elected by participating employers and the self employed;
- selected and designated by state governments (one or more per state), based on geographic units;
- recognized by the federal government who would override opposing state laws, and make start-up expense grants for those recognized and qualified HIPCs;
- in possession of a territorial franchise and become gatekeeper for the tax exclusion in exchange for taking all comers, community rating, continuity of coverage, no preexisting condition limits, etc.

The HIPC would act as a purchasing agent for small employers and individuals.

- It would contract with managed care health plans to offer enrollment to all employees of participating employers in annual open enrollments. Plans would cover uniform effective basic health insurance benefits, as defined by federal law.
- It would contract with employers to enroll their employees in contracting plans. It would accept all employment groups and all people in groups. It would not exclude groups or individuals based on health status. It would contract for continuity of coverage.
- It would manage competition (including risk adjusting premiums).
- It would charge employment groups community rates (with possible demographic adjustments).
- It would manage the Medicaid-private insurance interface; manage health insurance earned income tax credits and transferrable tax credits (if any).
- It would manage COBRA continuity for participating employers.
- It would measure and monitor quality, compliance with program goals.
- It would prepare informative materials for consumers.

Participating health plans would agree to:

- meet a definition of managed care;
- accept all enrollees without waiting periods or exclusions, and cover them for the year of enrollment for a price set in advance;
- set a "community rate;"
- guarantee renewal (unless they withdraw from the program entirely);
- cover the standard benefit package;
- provide an agree-upon data set on outcomes and quality;
- bear full risk (HIPCs do not bear risk).

Participating employers would agree to:

- offer coverage to all full-time employees and their dependents without waiting periods or exclusions;
- continuity of participation (i.e., rules to prevent opportunistic switching in an out);
- make fixed defined contributions not to exceed the price of the lowest-priced plan offered by the HIPC;
- make payroll deductions; make secure payment arrangements for employer and employee contributions.

9. If this is a good idea, why hasn't it happened out there in the free market of America?

The main problem is that there is a wide variation in premiums among groups, and the low-cost groups won't voluntarily pool with the high-cost groups. If only high-cost groups participate1 the pool is destroyed by a spiral of adverse risk selection.

I believe this is short-sighted. Eventually, low-cost people become high-cost people, at which point they wish they had been pooled.

My point here is that some powerful incentive is needed to motivate the better-than-average risks to pool with the worse-than-average risks.

I recommend that we put the power of the tax code behind HIPCs. Cover America sea-to-sea with HIPCs. Then condition eligibility for the exclusion of employer-paid health insurance on purchasing through a HIPC.

Once in, small employers of better than average risk will of course realize important advantages including:

- great economies of scale in administration; and
- stability of rates, because rates will be based on thousands of enrollees.

10. With HIPCs in place and working effectively, we could see a path to universal coverage much easier than any other we see today.

Wide variations in premiums make it hard or impossible to mandate employer participation. HIPCs could assure employers of availability of coverage at competitive community rates.

A limit on tax-free employer contributions at the level of the price of an efficient plan is an essential part of a market reform strategy. Moreover, it is a good source of revenue to subsidize coverage for the uninsured.

Beyond special interest groups complaints, there are three objections to such a limit:

- Concern whether it will keep up with medical costs.
- Concern over geographic variations.
- Concern over wide premium variations among groups within an area.

A limit tied to the price of the low-priced plan in each HIPC area could avoid all these objections. The cap would apply to everybody in the area, not just those purchasing through the HIPC.

11. Implementation steps to universal coverage might go something like this:

- All employers are required to cover all full-time employees (i.e., offer coverage and make a defined contribution equal to 50–100 percent of the price of the lowest-priced plan in the relevant HIPC area). Payroll withholding of employee share required.
- Coordination of coverage rules regarding dependents. (Like COB.)
- Payroll tax on all non-covered employment (part-timers).
- Self-employment and/or AGI tax for those who have escaped above taxes. (Everybody contributes in relation to ability to pay.)
- HIPCs offer to enroll anybody not covered through employment and to pay the price of the lowest-priced participating plan. The HIPC would bill the state for premiums not paid by employers.

The funds for these subsidies would come from:

- federal (and state) income, payroll tax revenue savings realized from the limit on tax-free employer contributions;
- payroll taxes and AGI taxes on those who escape the mandate;
- state revenues previously devoted to care of uninsured (e.g., state subsidies to counties for Medically Indigent Adults in California; Bad Debt Free Care pool in Massachusetts, etc.)

RESPONSES OF PROFESSOR ENTHOVEN TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question No. 1. How would your system of Health Insurance Purchasing Cooperatives (HIPC's) be organized?

Answer. There are several ways this might be done. The question deserves further study. I am looking for favorable precedents.

One good way would be as follows:

(a) The governor in each state would designate one or more HIPC areas.

(b) The governor would appoint initial directors, for staggered terms, chosen from a list of nominees by employer, labor and civic organizations. Subsequently, some of the directors would be elected by participating employers.

(c) There would be strong conflict of interest provisions for directors and staff, including prohibitions on links to providers or provider organizations servicing the HIPC, and prohibitions on political fund raising by directors.

My own preference would be for direct action to create HIPCs with exclusive territorial franchises, and accountability partly through the political process and partly through election by the constituency served.

As is the case with all political institutions, there is no ideal.

Question No. 2. Who would make decisions about limiting the numbers of HIPCs?

Answer. The governor. I do not favor multiple competing HIPCs without territorial franchises.

However, I believe we should be open to arguments for and against competing approaches.

Question No. 3. How would this work in rural areas?

Answer. There are several strategies that might be tried in rural areas, depending on the circumstances.

One would be for the HIPC to seek out and encourage metropolitan-based HMO's to open primary care satellites in rural areas.

Another might be "competition for the field" where "competition in the field" isn't practical. A HIPC might issue a RFP for a private sector managed care organization to create and operate a managed care system. This might be coupled with competitive contracts for tertiary referral care.

I think key elements include:

(a) stable medical purchasing power;

(b) some consolidation on the demand side; and

(c) prospective payment and management of a system of care as opposed to traditional fee-for-service, solo practice and remote third-party payment (as in "Americare.") The Jackson Hole Group is convening a special meeting focusing on this issue. The participants will be people experienced in organizing and purchasing rural health care. If a member of the Senate were interested in participating, he or she would be welcome.

Question No. 4. Who would decide the membership of HIPCs?

Answer. Enabling legislation. See Answer (1).

Question No. 5. How would you avoid adverse selection?

Answer. It is not so much "avoid" as manage. I have written extensively about the strategy of Managed Competition. See e.g., A. Enthoven, "Multiple Choice Health Insurance: The Lessons and Challenge to Employers." Inquiry, Vol. 27, No. 4, Winter 1990.

COMMENTS ON TOBY COHEN'S PIECE

Toby Cohen is angry at Senator Kennedy for "deserting" the Health Care for All Americans Act of 1979 and cosponsoring Senator Mitchell's HealthAmerica, "a plan with a hole its cost containment side as gaping as the leak in the Enthoven plan." I think Toby Cohen is correct about the ineffectiveness of the cost containment provisions of HealthAmerica.

I have proposed that we in America create a system of managed competition in which powerful market incentives would motivate health care providers to find ways to improve quality of care and service while cutting cost. The guiding force would be informed cost-conscious consumer choice. But Toby Cohen never refers to my phrase "informed cost-conscious consumer choice." Instead she caricatures it as an attempt "to *drive* most of us into HMOs" using "*pain* in the pocketbook," "*compulsion,*" membership "driven into an HMO," "Enthoven's *goading,*" "*regimented* into collectives," etc. (Italics added.)

I suppose I should be grateful the writer didn't also say "whipped," "beaten" and "tortured."

Frankly, this is not a serious piece of public policy analysis. It does not represent the editorial views of the *New York Times.* The editorial views of the Times favor my managed competition proposals, as the enclosed editorials illustrate.

It is very disappointing indeed that a United States Senator would waste his time and mine, and the taxpayers money over such a childish piece of name calling by an angry person whose views are obviously so far out of the mainstream of American thought.

To represent more accurately what I am proposing, I enclose a copy of the cover story from the April 1992 World Monitor.

'LETTERS SUNDAY, NOVEMBER 17, 1991

The New York Times

Founded in 1851

ADOLPH S. OCHS, Publisher 1896-1935
ARTHUR HAYS SULZBERGER, Publisher 1935-1961
ORVIL E. DRYFOOS, Publisher 1961-1963

ARTHUR OCHS SULZBERGER, Publisher
ARTHUR OCHS SULZBERGER JR., Deputy Publisher

MAX FRANKEL, Executive Editor
JOSEPH LELYVELD, Managing Editor
WARREN HOGE, Assistant Managing Editor
DAVID R. JONES, Assistant Managing Editor
CAROLYN LEE, Assistant Managing Editor
JOHN M. LEE, Assistant Managing Editor
ALLAN M. SIEGAL, Assistant Managing Editor

JACK ROSENTHAL, Editorial Page Editor
PHILIP M. BOFFEY, Deputy Editorial Page Editor

LANCE R. PRIMIS, President and General Manager
RUSSELL T. LEWIS, Sr.V.P., Deputy General Manager
JOHN M. O'BRIEN, Sr.V.P., Deputy General Manager
ERICH G. LINKER JR., Sr.V.P., Advertising
WILLIAM L. POLLAK, Sr.V.P., Circulation
ELISE J. ROSS, Sr.V.P., Systems
JAMES A. CUTIE, V.P., Marketing

Is It Health Care Reform? A Test

President Bush, jolted by Harris Wofford's shocking victory in the Pennsylvania Senate race in a campaign calling for health care reform, now seems moved to develop a health care proposal of his own. It's about time. With 40 million Americans uninsured, and everyone else socked with double-digit hikes in premiums, the need to provide universal, affordable care is obvious.

Scores of plans are now before Congress. Some call for a Government insurance program modeled on Canada's. One proposed by Senate Democratic leaders would require employers to insure their employees or else pay a tax to defray the cost of public insurance. Another proposed by the Heritage Foundation, a conservative policy organization, would require everyone to buy insurance with the help of tax credits. And now the White House plans to weigh in.

What principles should determine whether any plan merits support?

First, the plan should rely upon competition, not regulation, to guarantee low prices and high quality. Government regulators can't weed out incompetent doctors any better than they can eliminate incompetent bank managers. By this yardstick, both the Canadian-style plans and the Senate leadership's proposal fall short.

Second, the plan should rely on sophisticated purchasing agents because many individuals aren't capable of shopping for insurance on their own. They don't know how to evaluate doctors or monitor treatment. This principle works against the Heritage plan, which supports individual purchasers.

•

The plan that best fulfills these two principles is called managed competition; its principal architect is Alain Enthoven of Stanford University. Individuals would be organized into groups headed by sophisticated sponsors, say an employer, who would negotiate coverage with a fixed panel of doctors and hospitals and would monitor treatment. Health care providers would have to compete to win contracts from the sponsors, and would thus be forced to offer high-quality care at attractive prices.

New Federal laws will be needed to bring about managed competition. Here are some essential ingredients:

Spur Cost-Conscious Choice: Many consumers choose costly fee-for-service plans over cheaper managed-care plans because the tax law allows them to deduct the full cost of either choice. This problem could be mitigated by limiting tax deductions to the cost that a managed-care plan would charge for basic coverage. The Heritage tax credits are structured to provide consumers incentive to choose low-cost plans, but the Senate Democratic plan does not do so.

Prevent Discrimination: Insurers have ferocious incentive to tailor their plans to exclude chronically ill applicants, whose treatment is very costly. To prevent this discrimination, Congress would need to require that tax-deductible plans not exclude applicants on the basis of medical condition or drop enrollees for any reason other than nonpayment of premiums.

Combine Small Employers: To prevent small employers from hiring only healthy applicants, as a way to minimize health care costs, Congress could require that they join together in large groups to buy insurance or forfeit tax deductions for health-care premiums.

Create Public Sponsors: For people who have no other recourse, Congress needs to provide automatic access to a public sponsor offering managed care. The premium would be based on income.

Override State Obstacles: Many states, succumbing to lobbying by organized medicine, have obstructed managed-care plans. Some states limit the penalties sponsors can impose for using doctors outside the plan; other states force sponsors to accept any doctor who applies, thereby making quality control impossible. To solve this problem, Congress needs to forbid state restrictions on managed care.

When the White House finally gets around to proposing reform, its plan should be judged by three basic tests: Does it compel consumers to choose low-cost coverage? Does it provide universal access to group coverage? And does it strip away legal obstacles to managed care?

If the answers are yes, and the plan is implemented, then managed care will flourish. And no longer will Americans need fear the financial ruin of catastrophic illness.

A Cure for Health Costs

The world's biggest economy pays too much for health care—and gets too little. A management expert offers this new blueprint for reform.

BY ALAIN C. ENTHOVEN

American health care costs too much: more than $800 billion this year, approaching 14% of GNP. Canada and Germany get their health care for less than 9% of GNP, Japan and Britain for much less. On the present trajectory, next year Americans will spend more than three times on health care what they'll spend on national defense, more than twice what they'll spend on education. These costs are straining public finances. *How and why has this happened?*

Medicare outlays for older Americans, about $88 billion in 1988, will reach $130 billion this year. Medicaid outlays for poor people, $54 billion in 1988, will be more than $104 billion this year.

Medical costs are a disaster for much of the US private sector. One of General Motors' big problems is an unfunded liability of $16 billion to $24 billion for retiree health care. The total for the whole private sector is well over $300 billion. These are resources that won't go into plant modernization or product engineering. America has too many hospital beds (they're about 64% occupied), too many medical specialists doing too much surgery, and too much high-tech equipment.

The US medical care system was not organized for quality and economy. It was organized to meet the conflicting professional and financial interests of doctors, hospitals, and insurance companies—and made worse by the inflationary way in which employers and unions buy medical care. There is practically no accountability for quality of care or costs, little incentive to do things in less costly ways.

Let me explain by contrasting the health-care system that we in America now *have* with the health-care system we *need*. I'll follow with some suggestions as to how we can get from here to there.

ADVERSARIES WITH AN 800 NUMBER

The system we need would be made up of cohesive organizations attracting the loyalty, commitment, and responsible participation of doctors who would under-

High overhead: PET scan is one of many high-tech devices driving up health-care costs.

American health care needs a market-enhancing regulatory structure comparable to the Securities and Exchange Commission.

stand and accept the proposition that economy in health care is a worthy goal.

The system we have is an adversarial relationship between independent doctors and third-party payers. Most doctors feel no responsibility to control the costs to the third-party payer. They are taught that their first and only responsibility is to the patient.

An article in the Journal of the American Medical Association three years ago reported that a majority of doctors would deceive the insurance company to get a claim paid if they felt it should be paid. Do a rhinoplasty (the cosmetic procedure known as a "nose job," usually not covered by insurance) but report it as a septoplasty (the presumably medically necessary procedure to open nasal air passages).

Doctors feel that restraints by third-party payers are an unwarranted infringement on their professional autonomy. Think how you would feel if you had decided your patient needed to be hospitalized, but first you had to call an 800 number and get permission from a computer-assisted nurse?

The payers can't beat the doctors in such games. It's time to cut a different kind of deal.

FEE-FOR-SERVICE OR FEE-FOR-EFFICIENCY?

The system we need would align the incentives of doctors and the interests of patients in high-quality economical care. Providers of medical care—doctors and hospitals—and payers would contract selectively for global units of care; that is, units based on person years (individual contract duration) or complete cases (operations, for example). The parties would agree on prices set in advance, with providers at risk for resource use; that is, taking the risk of any loss owing to their use or overuse of medical resources.

The Texas Heart Institute has made this approach famous: open-heart operations on a complete-case basis for a fixed price.

The system we have, based largely on fee-for-service payment, often pays more to poor performers than to good ones. Doctor A makes the correct diagnosis promptly and does the appropriate (i.e. best for the patient) procedure with skill and proficiency so the patient's problem is solved with no complications. Doctor B needs many repeated tests and visits to reach a diagnosis, does a procedure with poor proficiency, creates complications (like infections), and doesn't really solve the patient's problem. Guess who is likely to be paid more money under fee-for-service.

OUTCOMES AND ALTERNATIVES

The system we need would be designed to produce favorable health outcomes efficiently. It would systematically gather data on treatments, resource use, and health outcomes (did the patient survive six months? did the treatment solve the problem? can the patient walk? work?). Clinical decisions would be based on analyses of such data. Dr. Paul Ellwood, a leading health-policy thinker, calls this "outcomes management."

The system we have knows little of outcomes data, virtually nothing of the relationship of resource use to outcomes. The scientific information base underlying much medical practice is small. For most medical treatments doctors simply cannot point to good relevant data linking outcomes, treatments, and resource use to support their choice of therapy in comparison with other reasonable but less costly alternatives.

PREVENTION AND FOLLOW-UP

The system we need would emphasize prevention, early diagnosis and treatment, and effective management of chronic conditions to prevent them from becoming serious acute problems. For instance, it would use computers to send reminders to parents of children scheduled for immunizations—and follow up until the children were immunized.

The system we have does poorly on prevention and primary care. Roughly 40% of children aged 1 to 4 lack basic immunizations for childhood infectious diseases. The US was down to 2,800 measles cases in 1985, but up to more than 18,000 by 1989. About 20% of white mothers and 40% of black mothers don't get prenatal care in the first trimester of pregnancy. But the US system is quite open to the financing of very costly high-tech care, such as neonatal intensive care for low-birthweight babies.

TOTAL QUALITY MANAGEMENT

The system we need would practice "Total Quality Management/Continuous Quality Improvement," the powerful management philosophy developed by W. Edwards Deming, Joseph Juran, and Philip Crosby that has led to the major gains in quality and productivity that we associate with world-class industrial competitors like Honda, Hewlett-Packard, and Xerox. The health services industry is virtually untouched by this movement. Only in the late 1980s did a few leading health-care organizations,

ALAIN C. ENTHOVEN has written widely on economics, health care, and systems analysis in a career ranging from Oxford University (Rhodes scholar, visiting fellow) to MIT (economics instructor), the RAND Corporation (economist), the Pentagon (assistant secretary of defense for systems analysis), and Litton Medical Products (president), not to mention numerous other posts in the US and abroad. Since 1973 he has been teaching at his alma mater, Stanford University, where he is both professor of public and private management and professor of health research.

Under the 'magnet': New ways of peering into body raise questions of who pays, who benefits.

such as the Harvard Community Health Plan and Intermountain Health Care, get seriously committed to continuous quality improvement. Health-care leaders such as Intermountain's Brent James and Harvard's Donald Berwick have made an impressive case that Continuous Quality Improvement could generate significant annual productivity improvements.

The system we have violates modern concepts of quality management in many ways. It works on what Dr. Berwick calls "the bad apples theory." If a bad outcome happened, it must have been because some bad person messed up, and the system should find and penalize him. Not surprisingly, this attitude leads to cover-ups and evasion of accountability.

The system we have doesn't embody proper statistical thinking. It looks at one case at a time to see what went wrong, rather than, say, 500 cases at a time to see what correlates with good outcomes. Physicians are socialized to have a self-image as autonomous actors whose correct decisions will save the patient. This works against the teamwork and process-mindedness, cutting across departments and professions, that is needed for Continuous Quality Improvement.

SELECTING DOCTORS

The system we need would be based on organizations that carefully select doctors for quality and efficient practice patterns. Performance varies widely among physicians. Patients have a hard time assessing technical aspects of quality. That takes analysis of complex data from many patients. And most patients can't tell whether their doctor is up-to-date or not. They need systematic help.

The system we have has no effective mechanism to protect the population from poor or out-of-date doctors. Malpractice litigation doesn't separate the good from the bad. State regulators find they have to be able to prove unacceptable behavior in court to lift a medical license. The defendant doctors can tie them up in court for years, then move to another state.

MATCHING DOCTORS AND NEEDS

The system we need would carefully match the numbers and types of doctors to the needs of the population served, with plenty of primary care physicians to assure patients convenient access to a doctor, and a number of specialists small enough to assure that each will have a full schedule seeing just the types of patients he or she was trained to see. This keeps the specialists proficient in their specialties and reduces their incentives to do unnecessary surgery.

The system we have has too many specialists and too few primary care doctors (general internists, family practitioners, pediatricians). The numbers and types of doctors turned out by residency programs are driven by the needs of government-subsidized training programs for cheap labor in the form of residents, and by student expectations of higher incomes and easier lifestyles in the specialties.

Government can't pick good doctors or health-care organizations any more than it can pick good bankers.

ECONOMIES OF SCALE

Encouraging excellence would concentrate complex procedures in high-volume regional centers to take advantage of economies of scale and experience. Research shows that, for complex operations like open-heart surgery, practice makes perfect: High volume is associated with low death rates and low costs.

Preventing duplication proliferates facilities for heart-surgery and other procedures—facilities that remain underutilized. In California, more than a third of the hospitals doing open-heart surgery have annual volumes below the 150 minimum needed for proficiency and patient safety. In Des Moines, Iowa, in 1987, one hospital did seven kidney transplants while another did ten. They should have been done at the University of Iowa Hospital, about 100 miles away, which handled 75 cases that year.

MAKING TECHNOLOGIES PROVE THEMSELVES

Technology assessment would put the burden of proof on expensive new technologies—and require their worth be proved before they are put in general use. It would conduct ongoing technology assessment and facilitate a rational response to the information produced.

Preventing premature use the courts, the media, and unrealistic patient expectations are forcing health insurers to pay for extremely costly technologies—such as autologous bone marrow transplants for AIDS—before they have been shown to be effective. Many very costly technologies are put into practice before they have been thoroughly evaluated.

BENEFITS VERSUS COSTS

Encouraging consumer cost-consciousness would encourage informed cost-conscious decision-making by doctors. They wouldn't do things having very high costs and very low marginal benefits. For example, Genentech has very successfully marketed TPA, a drug based on recombinant DNA technology, that dissolves blood clots diagnosed as causing heart attacks—for about $2,200 a treatment. Recent large-scale controlled trials show that intravenous streptokinaise is just as effective—at about $200 a treatment. Genentech's experts are debating the results. But TPA wouldn't sell much in a cost-conscious system.

ACCOUNTABLE HEALTH PARTNERSHIPS

How can Americans get from the system we have to the system we need? There isn't a simple single easy intervention that can get us there. We need a comprehensive strategy by *purchasers* that matches in sophistication the complexity of the *industry* we're trying to change.

A group of health-policy analysts and industry leaders have been meeting annually at the home of Dr. Paul Ellwood in Jackson Hole, Wyoming, to discuss what such a comprehensive reform might look like. Here, in brief, are some of the main Jackson Hole Group proposals.

First, purchasers need to direct their purchasing to what Ellwood calls Accountable Health Partnerships." These are defined as:

Organizations that integrate the func-

Cost-Conscious Health Care Does Exist

Is the health-care system America needs purely theoretical, or are there reasonable approximations to it in existence in actual practice? I believe such organizations exist in the form of prepaid multi-specialty group practices such as Kaiser Permanente, Harvard Community Health Plan, and Group Health Cooperative of Puget Sound, and in other large multi-specialty group practices that operate partially on a per capita prepayment basis like the Mayo Clinic in Rochester, Minnesota, the Park Nicollet Medical Center in the Twin Cities, and the Palo Alto Medical Clinic.

Some readers may have a friend or family member who was treated poorly by an organization like these. The world of medicine, like the rest of the world, is imperfect. And organizing medical care for quality and economy is very difficult to do. Nobody is saying these organizations are perfect, even close to it. Some may not do a good job. Competition could make them better.

What I am saying is that if you look at how the good ones are organized, you'll see something that makes sense.

And if you look at the performance of the good ones, you'll see a promising model for the rest of the health-care system.

The RAND Corporation did an experiment in which people were randomly assigned to traditional fee-for-service care with third-party payment or to Group Health Cooperative of Puget Sound, a health maintenance organization (HMO). Over a five-year period, Group Health cared for its patients at a cost 28% less than fee-for-service—and produced equal health outcomes. It did so in the absence of any price competition. (Many other nonrandomized comparisons have produced similar results.)

I asked Group Health's medical director: "If you had had significant price competition and mostly price-conscious customers, could you have reduced costs another 10%?" The answer: "Easily, if we had had such an incentive."

One important reason why organizations like these don't serve more Americans is that many employers do not offer their employees the opportunity to join them. Or, if they do, most employers either pay the whole cost whether the employee chooses traditional fee-for-service or a less costly alternative, or at least the employer pays substantially more on behalf of the employee who chooses fee-for-service. Back in the 1950s and

tions of care provision and insurance, so that providers share in the risks of the cost of care and are motivated to reduce cost.

Organizations that are publicly accountable for quality and cost per capita using "generally accepted accounting principles" for outcome measurement and reporting (taking account of patient mix, for example).

Organizations with greatly improved computerized clinical information systems that generate data relating outcomes to treatments and to resources used as a guide to improved medical practice.

Organizations that can contract selectively with the numbers and types of doctors needed for the population served; that can select doctors and other providers; and that can contract at will (i.e. not renew contracts of poor performers without having to prove their deficiencies in court).

STANDARDS BOARDS

American health care also needs a market-enhancing regulatory structure, comparable to what the Securities and Exchange Commission and the Financial Accounting Standards Board do for financial markets. Markets require information to function effectively. The Jackson Hole Group proposes an "Outcomes Management Standards Board" to set data collection and reporting standards for Accountable Health Partnerships and to establish a national data system for patient outcomes and other quality measures.

Costly health technology decisions are now often being made irrationally by the courts and the media—who don't appear to understand why insurance companies should not be forced to pay for expensive therapies of unproven efficacy. Individual health plans and employers can't stand up to these pressures. They need help with such medical-lexicon decisions as: Under what conditions, if any, can patients benefit enough from liver transplants, autologous bone marrow transplants for metastasized breast cancer, and the like to justify the cost? These decisions must be made collectively by an informed authoritative process that can command respect and support. If the medical societies or insurance companies try to do it, they get sued for anti-trust violations.

The group proposes a "Health Standards Board" to assess medical technologies and medical practice effectiveness and advise on a list of "uniform effective health benefits" that would be covered by all tax-favored health insurance plans.

Next, consider that roughly half of American workers are employed in groups of 100 or less or are self-employed. These groups are far too small for the spreading of risk, for economies of scale in administrative costs, or for acquisition of the expertise needed to purchase health care effectively. Competition at the level of individual choice is blocked in small groups because such groups are not large enough to be able to offer competing health-care plans to employees. Employees in these groups need to be pooled into larger units. Richard Kronick, of the University of California, and I have proposed "Public Sponsors" and "Health Insurance Purchasing Corporations," collective purchasing agents for small employers and individuals.

MANAGED COMPETITION

As it is, insurers often profit more from selecting good risks and segmenting markets (see box) than from joining with doctors to manage care efficiently, because the health-care market in general has not been structured appropriately. To correct this, I recommend to large employers and to Health Insurance Purchasing Corporations a strategy called "managed competition." Its purpose is to reward with more subscribers those health plans that provide high-quality care and effectively control cost, and to take the reward out of attempts to select risks and segment the market. The idea is to create a market driven by informed cost-conscious consumer choice.

Under this strategy, the large purchasers would:

- Qualify the competitors; preselect high quality cost-effective comprehensive care organizations to participate.
- Run an annual open enrollment in which covered beneficiaries make choices and the health plans accept all comers.
- Structure prices to consumers so that consumers are fully price conscious in choice of plan; i.e., if Plan A costs $5 per month more than Plan B, those subscribers who choose Plan A pay $5 more.
- Contract for a standardized benefit package (list of covered services) to focus competition on total price and quality, not on whether Plan A offers birth-control pills while Plan B offers eyeglasses.
- Compensate the plans that enroll a disproportionate share of people with higher expected medical costs.

MARKET FORCES

This all sounds pretty complicated. Why not just turn the whole US health care system over to the government and let Washington run it? There are a lot of answers to that. I would be concerned by the possibility of a very large-scale replay of the Federal Savings and Loan and Federal Deposit Insurance Corporation fiascoes. Government can't pick good doctors or health-care organizations any more than it can pick good bankers. It can't create or order the system Americans need. I'd be concerned about the quality and economy of care produced by a government-run system.

But the answer I'd stress here is that we need to go from today's inefficient, wasteful system to a truly efficient one. And the only forces known to man that can transform inefficient industries into efficient ones are market forces. Government, especially the US government with all its checks and balances, just can't do that. What government might be able to do is help create a system of managed competition in which market forces take the health-care system from the one we have to the one need. WM

1960s, when health insurance was cheap, employers promised their employees they'd pay the full cost or most of the cost of the traditional fee-for-service plan, and they are now reluctant to antagonize employees by saying they will only pay for the less costly HMO.

As it is, most US labor disputes these days involve health-care issues. But the present pattern weakens or destroys the employees' financial incentive to choose the less costly health care plan—they don't get to keep the savings. Worse yet, this destroys the health plan's incentive to be less costly. Why struggle to cut an extra dollar out of your monthly premium if the people who make the decision whether or not to join you don't get to keep the dollar?

In other words, competition among health-care organizations over quality and total cost of care per person has not been tried. The market has not yet been structured appropriately. Insurers profit more from selecting good risks and segmenting markets than from joining in partnerships with doctors to manage care efficiently. Moreover, comparative data on health outcomes are not available.

It's hard for *cost-effective* alternatives to prosper in a *cost-unconscious* environment. Indeed, with today's employer policies, it is little wonder the US has an inflationary spiral.—A.C.E.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

[May 6, 1992]

Health care reform is a topic in which we all have a stake.

Over the last recess, I held public meetings in Utah on the problems of our health care system.

I heard from senior citizens on fixed incomes struggling to meet their health care bills.

Retirees with corporate sponsored health plans are confused and do not understand why their out-of-pocket costs rise while their benefits shrink.

Likewise, Medicare beneficiaries face escalating medigap insurance premiums. Although they qualify for our Medicare program, they still do not feel secure about their health insurance as they reach deeper and deeper into their savings to pay for insurance and for their prescriptions.

I also heard from many doctors who were concerned about the red tape that goes along with federal reimbursement policies. Some physicians may no longer wish to participate in the Medicare program, which will hurt our elderly citizens. I also heard frustration regarding the current, hostile medical malpractice environment that raises insurance costs, engenders the practice of defensive medicine, and generally interferes with the traditional doctor-patient relationship.

About one-in-ten citizens in my state of Utah lack health insurance. Some of these uninsured Utahns attended my meetings and shared their frustration and their difficulties in getting what most of us take for granted—good health care for their family members who are sick.

I heard from several representatives of our vital small business community whose health insurance costs are skyrocketing to the point that those who offer insurance feel compelled to consider dropping it and those who would wish to offer this benefit cannot afford it.

In the midst of a recession small employers are particularly concerned that imposition of employer mandated health insurance could literally spell the life or death of their business.

I also heard from managers of health care providers and insurers—our hospitals, clinics, group practices, testing labs, and insurance firms—who told me of their unrelenting daily battle against red tape and almost incomprehensible regulations lust to provide needed medical services for our citizens.

From our state government, I heard further elaboration on the tale that is being told all across our country: State spending on Medicaid is exploding with no end in sight.

I am certain that all of my colleagues on this Committee have heard similar concerns expressed by constituents. The inextricably linked problems of access and cost are straining the American health care system. We all know this. We all are committed to addressing these problems.

Achieving an consensus on solutions to these problems will be difficult, particularly in light our large annual budget deficit and ever increasing national debt—now approaching $4 trillion.

It is especially troublesome to me that the federal government is paying more this year to service the national debt than we are to finance Medicaid and Medicare. Any solution to our health care problems cannot and should not exacerbate our problem with the deficit and growing national debt.

For my part, I pledge to work with you, Mr. Chairman, and my fellow colleagues on this Committee and in the Senate in fashioning measured, beneficial, and necessary reforms to the system.

Health care reform is a policy issue unlike any other domestic policy issue—it affects every one of our 250 million citizens.

To succeed in this endeavor, it will be critical that all of us in the Congress do everything in our power to see that the American public is actively engaged in this debate.

I feel compelled to restate my general view that the key to success in this endeavor is to employ, wherever possible, market-based reform mechanisms such as contained in the proposals of President Bush and the Senate Republican Health Care Task Force. I believe that, over time, a strong majority of the Congress and the public will see the benefit of this approach.

As this Committee continues its deliberations over this important issue, I look forward to hearing from today's panel of expert witnesses.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

[May 7, 1992]

Mr. Chairman, I look forward to participating in this hearing this morning. Today's subject is I believe crucial to the success or failure of health care reform. I know that many of my colleagues share my strong feeling that any meaningful reform of our health care system must include the reduction in the rate of growth of health care costs. It is the frightening prospect of our unchecked health care cost growth rate that is precipitating the willingness of many Americans to consider major health care reform. Mr. Chairman, I commend you for addressing this issue head-on today and bringing together this knowledgeable group of experts.

I believe that Americans are generally satisfied with our health care system. We like knowing that if we are rushed to the hospital with a serious condition, we are going to be treated by the most skilled physicians and nurses and with the most advanced equipment in the world. We like the freedom of choosing our own doctors and the almost immediate availability of treatment when we want it or need it.

On the other hand, Americans are deeply concerned about rising costs. Just last month, I was in Utah talking to people about health care reform; clearly the high cost of health care was a primary concern for many constituents. We cannot separate the problem of high health care costs from the issue of access to health care. They are inextricably woven.

The tendency of today's health care debate is to focus on reforming the health care delivery and financing systems, while ignoring the external environment in which these systems operate. Demographics, genetics, lifestyle and behavior choices, working environments, and the interaction between the American health care and legal systems—all are influences that can't be ignored.

Unfortunately, these influences are more easy to recognize than to quantify and are often lost in the debate. Nevertheless, these factors affect the health care system and, together, can impair health status, increase demand for services, raise costs, and create barriers to obtaining care.

For example, the number of people age 65 and over is expected to increase from 32 million in 1990 to 53 million by 2020, and to 72 million by 2040. In other words by the year 2040 20 percent of all Americans will be age 65 or over. This has significant implications for public and private spending under Medicare and for long-term care.

The genetic makeup of individuals has a profound impact on the health care financing and delivery system. Family histories display common risk factors for a variety of diseases, including cancer and heart disease.

Many choices individuals make about their lifestyles put them at higher risk of serious illness and increase spending for health care. Smoking costs the nation $52 billion annually, with drug abuse following close behind at $44 billion. We spend $4.4 billion on gunshot wounds each year alone. Over one million women seek medical care every year for injuries caused by domestic beatings. The total annual cost of sexually transmitted diseases, excluding AIDS, is over $3.5 billion. The cost of AIDS is projected to be between $5 and $13 billion in 1992.

Our legal system contributes to the problem of rising health care costs in several ways.

We have a medical liability crisis on our hands. In the 1980's the frequency of malpractice claims and the size of awards dramatically increased, driving up the cost of medical malpractice insurance. The average medical liability premium for obstetricians and gynecologists in 1989 was $37,000.

The fear of being sued is driving practitioners out of high risk specialties, especially in the rural areas of our country. This is certainly true in Utah where more than half of the general and family practitioners have stopped providing obstetrical care.

In an effort to protect themselves from lawsuits, physicians practice defensive medicine by ordering excessive tests, follow-up visits, and consultations. Estimates of the cost of defensive medicine range from between 5–20 percent of total health care spending.

I have introduced my own medical liability reform bill and I look forward to working with other members of the committee in seeing that this issue is addressed.

Another reason for increasing health care costs is antitrust laws that prevent providers from merging to reduce excess capacity or duplication of services. I have to say that I think the burden of proof in these situations ought to be on the government to demonstrate the need for this particular type of antitrust enforcement. For example, Utah's heart transplant program had to be dismantled due to antitrust concerns. This program had survival rates of over 90 percent and a national reputation for being cost effective.

We need to study the antitrust laws to see whether enforcement is properly directed. Where appropriate, hospitals ought to be allowed to merge and enter into joint ventures in order to reduce excess capacity or pool services, personnel, and expensive equipment. We also need to look at amending antitrust laws to permit hospitals and insurance companies, in consultation with the medical profession to compare and pool data for developing better methods of technology assessment and medical evaluation.

Antimanaged care laws are another concern. Again, we need to encourage innovation in health care delivery, not stifle it. It is possible that Medicaid cost growth could be reduced by encouraging greater reliance on coordinated care and providing states with greater flexibility.

The majority of states have mandated benefits and while many of these services are beneficial, they contribute to the cost of insurance. According to one study, mandated benefits comprise 15 to 20 percent of the cost of health insurance premiums.

I have heard testimony in this committee and in the Labor committee from representatives of small business who complain that their members would like to offer health care to their employees but are prohibited by the cost. Most small businesses operate on very small profit margins.

So these external factors drive up costs and the health care financing and delivery systems are often expected to overcome the effects of factors which these systems control either inefficiently or not at all.

There are also of course factors internal to the health care financing and delivery systems about which we should be concerned.

We all know that the health care financing system contains perverse incentives that increase health care spending. The third-party payment system tends to be the enemy of prudence. There is less incentive for patients and their physicians to be cost-conscious in making decisions about the use of medical services so long as someone else is picking up the bill.

There are similar problems with our federal tax policy Employers can deduct the cost of health insurance as a business expense, and employees do not have to declare this contribution as personal income. The tax preference insulates individuals and companies from the increasing costs of care because all the taxpayers are indirectly subsidizing health insurance and medical services. This is hardly an incentive for cost containment.

The way that benefits are designed also contributes to higher costs. For example, when there is inadequate cost sharing for hospitalization, the patient has an incentive to be hospitalized, even where less expensive outpatient care would suffice. Medicare covers most surgical procedures, but not outpatient prescription drugs. Even if drug therapy is a viable and less costly alternative to surgery, the incentive is still to have surgery.

Fee-for-service medicine provides incentives for physicians to increase services to patients. Motivated either by a desire to maximize reimbursements or to please patients, physicians may be tempted to perform more services, rather than provide only necessary and effective care.

The proliferation of new technology and services is an important contributor to higher spending. New technologies are often viewed as a profit source. Hospitals may add duplicative programs, equipment, and technology to attract physicians and patients.

The shortage and maldistribution of primary care physicians increases health care costs. When pregnant women do not receive prenatal care, they tend to give birth to low birth-weight babies that require expensive treatments in neonatal intensive care units.

We have all heard testimony in previous hearings to the fact that people living in rural or inner-city areas too often obtain their health care through emergency rooms and hospital clinics, which is an expensive way to receive care.

We know there are a lot forces converging to drive up the cost of health care. We have to address all of these forces. Once again, I commend you Mr. Chairmen for holding this hearing. And I look forward to what our panelists have to say about solving some of these problems.

PREPARED STATEMENT OF JOHN IMMERWAHR

My name is John Immerwahr. I am a senior research fellow at the Public Agenda Foundation and a Professor of Philosophy at Villanova University.

The Public Agenda is a nonpartisan, nonprofit research and education organization based in New York City. Founded 15 years ago by Daniel Yankelovich and Cyrus Vance, Public Agenda works to help the nation's leaders better understand

the public's point of view on major issues, and to help citizens better understand the critical policy choices the country faces. For the past two years, I have been the principal researcher on a Public Agenda project to explore what might be called "the public's starting point" on health care reform. That is, our purpose was to learn what kinds of concerns, misconceptions, information, misinformation, knowledge, and gaps in knowledge citizens bring to the policy debate on whether and how to change our health care system.

Today, we are providing you with copies of *Faulty Diagnosis: Public Misconceptions about Health Care Reform,* a full report on our research. This research included a review of existing survey data, a two-part national random sample survey—conducted in association with the Employee Benefit Research Institute (EBRI) and The Gallup Organization in June 1991 and January 1992—and 15 focus groups conducted in cities across the country.

In my remarks, however, I want to emphasize one central point: There is an enormous and potentially troublesome gap between the way leaders—whether they come from health care, government, business, or academia—think and talk about health care reform, and the way the public views it. The public defines the problem differently than most leaders do. And, their understanding of the major reform proposals this body is considering where it exists at all—is fragmentary or distorted. Unless this gap in understanding is addressed, miscommunication and miscues between decisionmakers and the public are almost inescapable. To change the nation's health system fundamentally without full public understanding of what these changes will mean is to court public policy disaster.

Let me make three brief points based on our research:

1. Polls suggest that the public's concerns about the health care system are the same ones troubling leadership—costs are too high and too many Americans are uninsured. These findings are misleading.

Many surveys, including our own, show that cost and the number of uninsured Americans are first and second in people's list of concerns about health care. But what people mean by the terms "costs" and "uninsured" is very different from what most leaders mean. When leaders talk about the cost of health care, they are generally referring to what the country spends as a whole—that is, the almost $750 billion spent in 1991 by businesses, by local and national government, and by individuals directly. They are concerned about the impact of the rising costs on the economy, on all levels of government, and on individuals.

When the public refers to the "cost" of health care, they are talking about what people pay out of their own pockets—for office visits, prescriptions, deductibles, copayments, or their share of premiums. Americans routinely endorse higher government spending on health care. They are basically unaware of what most businesses spend.

In focus groups conducted by Public Agenda, most respondents had very little conception of the size of the nation's health care bill, and some failed to see why this should be a matter of concern. When presented with statistics showing that the country spends about twice as much on health care as on defense or education, most respondents were astounded. Some even rejected the statistics, questioning the motives of the moderators.

The public also defines the "insurance problem" differently than leaders do. For leaders, the problem of the "uninsured" is the 35.7 million Americans whose companies don't provide insurance, who cannot afford to buy it on their own, and who make too much to qualify for Medicaid—mainly the working poor and their dependents.

For much of the public, however, the "insurance problem" lies in another area. Over half (54%) of Americans' believe that "many people over 65 have no health care coverage at all," and almost two-thirds (64%) believe that "many people on welfare have no health care coverage at all." While few would argue that health care coverage for these groups is perfect, these two groups are, ironically, among the few segments of the population already covered by government insurance programs.

For many Americans, the health insurance crisis is like the auto insurance crisis—it's expensive and a lot of people don't have it. What people don't realize is that in health care—unlike auto insurance—the costs they actually pay are the tip of the iceberg.

2. The public is outraged by what they view as waste and greed throughout the health care system. Most Americans believe we have a health care crisis, not a health care crisis. Therefore, they are very reluctant to consider changes that call for increases in their own costs or decreases in the services or choices they currently have.

For leaders, the health care cost explosion is a complex, multifaceted problem. Experts cite factors such as the duplication of technology and services, defensive medi-

cine, reimbursement procedures, patient expectations, health costs associated with poverty, crime, drug use, and teenage pregnancy, along with the costs of treating an aging population and the development and use of new technology.

For the public, the problem is much simpler. High costs are caused by waste and greed—overpaid doctors, wasteful hospitals, profiteering drug and insurance companies, and greedy malpractice lawyers. Fully 83% of Americans believe that "the most Practical and realistic way to provide health care coverage for people who don't have it now is to pay for it by cutting some of the waste, malpractice, high profits and salaries, or unnecessary paperwork in our current system."

In focus group after focus group, people recounted first-hand experiences with what they considered to be "outrageous" medical costs: hospital bills with "astronomical" charges for items such as band-aids or ice—items that people know can be purchased for a few cents, hundred dollar fees for a few minutes of a doctor's time, or prescriptions costing hundreds of dollars a month.

As long as people believe that the health care system is riddled with waste and greed, they will not be eager to talk about changes that reduce the services and choices they have. Nor will they be willing to relinquish the miracles of modern medicine. As one man commented when asked about the very high cost of trying to save a severely premature infant, "You are asking me to save money by watching some premature infant die when he has a chance of being saved, while you are still wasting the kind of money we are throwing away. No way."

3. Public understanding of the major reform proposals is incomplete and, in some cases, inaccurate. Current polling data indicating support for, or opposition to, of the major proposals before Congress are likely to change as people learn more about how these proposals would work.

Leaders are now engaged in a debate on the pros and cons of several major approaches to addressing the problems of the health care system—most prominently, a national health insurance system, a universal employer-based approach (play-or-pay), or comprehensive modifications to our current, voluntary, private insurance system. Among the public, only national health insurance has "name recognition" as a fundamental reform proposal.

While leaders disagree sharply about whether a national health insurance system is a wise course of action, they do share a common general definition—a universal insurance system paid for by taxes covering the large majority of health care costs for every citizen. Leaders know what national health insurance is, but they disagree about whether it's a good idea.

For the public, the situation is exactly the opposite. People national health insurance, they just disagree about what it is. In our survey, conducted in January 1992, 77% of Americans said they supported national health insurance, but only a third defined the proposal the same way leaders do—a universal system covering almost all costs for everyone. In focus groups, respondents often thought national health insurance would be optional or was intended primarily for the poor. People were basically unaware of other reform proposals.

The political debate on health care reform has leaped ahead of the public's current level of understanding. It is filled with miscues and crossed signals. The apparent consensus revealed in surveys is a house of cards that could fall apart with the first gust of reality.

If leaders want to reform American health care, they need to help people understand what the problems are and how the reforms will work. And they need to address the public's concern about waste and greed. People will not accept difficult changes until they confront the full magnitude of the costs of the system. They will not make sacrifices as long as they believe greed and waste are epidemic in health care. Moreover, the public must absorb and weigh the trade-offs entailed in the proposals for change, alongside the trade-offs evolved in staying with our present system.

Leaders have already had one painful lesson in the dangers of rushing to a health care solution before the public was ready. In July, 1988, President Reagan, backed by overwhelming bipartisan support, signed the "catastrophic care" bill to protect seniors from the costs of long hospital stays. Just a year and half later, angry protests from the elderly led to the bill's repeal. Leaders were stung by the response of the very group they thought they were helping. A similar political fiasco could well be on the way.

Thank you for your time and attention.

Attachments.

FAULTY DIAGNOSIS: REPORT SUMMARY

Research conducted by the Public Agenda Foundation, in association with the Employee Benefit Research Institute (EBRI) and The Gallup Organization, suggests that the national debate on health care is badly off course. Although the public and its leaders seem to agree on the major problems facing the health care system—soaring costs and inadequate coverage—just beneath the surface, the public/leadership consensus breaks down.

What the experts say	What the public says

WHAT IS THE COST PROBLEM?

For experts and leaders, the issue is that the country's total health care spending is skyrocketing—estimated at almost $750 billion in 1991 and rising at twice the rate of inflation. Many experts estimate that the country will be spending over a trillion dollars annually by 1995.

For the public, the issue is that their own out-of-pocket costs are too high. Americans significantly underestimate what health care costs the nation as a whole. When respondents in focus groups were told that the nation as a whole spends twice as much on health care as on defense, they were incredulous.

WHO ARE THE UNINSURED?

For leaders and experts, the problem is the 35.7 million Americans whose companies don't provide coverage, who cannot afford to buy it on their own, and who make too much to qualify for Medicaid. They are mainly the working poor and their dependents.

For the public, the problem is in a different area. Many Americans think large numbers of the elderly and very poor have no health care coverage at all, when, in fact, these are the two groups currently covered by government insurance programs.

WHY ARE COSTS GOING UP?

For leaders and experts, the health care cost problem is complex and multi-faceted, including factors such as duplication of technology and services, defensive medicine, the health costs associated with crime and drug use, an aging population, and the development of new technology.

For the public, there is only one cause of high costs: greed. Americans blame high costs on unnecessary tests, overpaid doctors, wasteful hospitals, profiteering drug companies, and greedy malpractice lawyers. For the public, it all adds up to a *profits* problem, not a *costs* problem.

WHAT SHOULD WE DO ABOUT THE ELDERLY?

For leaders and experts, the aging of the population presents a major challenge. The elderly have greater health care needs and thus account for a disproportionate share of health care spending: In 1991, citizens over 65, who make up only 12% of the population, accounted for over one-third of America's health care bill. As the population ages, these costs are likely to rise.

For the public, this subject touches a raw nerve. Most Americans do not believe that aging is a major factor in driving up costs. Even when presented with statistics on the higher health care costs for older Americans, many are reluctant to consider the implications. As one Washington woman said: "It is true, but you shouldn't say it."

WHAT SHOULD WE DO ABOUT TECHNOLOGY?

For leaders and experts, both the *inappropriate* use of technology (duplication, unnecessary and unproven procedures) and the *appropriate* use of technology (the medical breakthroughs that improve and save lives, but at a very high cost) are causes for concern.

For the public, the only problem is the misuse of technology—a matter of waste, fraud and abuse. The public resists suggestions that society may have to place some limits on what can be made available.

OVER

What the experts say | What the public says

HOW MUCH SUPPORT IS THERE FOR NATIONAL HEALTH INSURANCE?

Although experts and leaders disagree sharply about whether national health insurance is a good idea, they do share a common definition. National health insurance is a universal system paid for by taxes covering a majority of health care costs for every citizen.

Surveys show broad public support (now above 75%) for "national health insurance," but this consensus is deceptive. Only 31% of Americans define the term the way leaders do, often believing "national health care" would be optional or not involve government. As one man said, "I am for national health care, but I don't want the government involved."

HOW MUCH SUPPORT IS THERE FOR "PLAY-OR-PAY"?

Most respondents in focus groups had never heard of this idea, and many regarded it skeptically—believing, for instance, that it would drive small companies out of business. Some thought employers would prefer to pay a tax to the government rather than fund insurance policies for their employees.

The public's top-of-the-head solution to any health care problem is to regulate costs and crack down on waste, fraud and greedy profiteering. The public does not believe that elimination of "waste" will mean less care for patients, only less profit for health care providers.

LESSONS LEARNED

The political debate on health care reform has leaped ahead of the public's current level of understanding. It is filled with miscues and crossed signals. The apparent consensus revealed in surveys is a house of cards that could fall apart with the first gust of reality.

Leaders should not expect quick solutions. Americans' current attitudes took years to develop, and, in many ways, they reflect what leaders have explicitly or implicitly told them for decades. Change in deeply-held values will come only gradually.

The public believes the health care system is riddled with waste and greed. Consequently, they are not eager to talk about choices that will increase their own costs or reduce the services they get. Nor are they ready to relinquish the miracles of modern medicine. As one man commented about the cost of attempting to save a severely premature infant: "You are asking me to save money by watching some premature infant die when he has a chance of being saved, while you still are wasting the kind of money we are throwing away. No way."

To order copies of Faulty Diagnosis, call Isa Simon at The Public Agenda Foundation: (212) 686-6610

The Public Agenda Foundation has developed materials based on Faulty Diagnosis for community and corporate awareness programs. To find out more about sponsoring Public Agenda's Condition Critical campaign in your community, call Scott Swenson at (212) 686-6610

PREPARED STATEMENT OF GERALD C. KELLER

Good morning, Mr. Chairman and Members of the Committee. I am Gerald C. Keller, R.D., Vice President of the American Academy of Family Physicians. I am pleased to be here today representing the Academy's 74,000 member physicians and medical students to discuss a topic of crucial national importance—containing our nation's health care costs.

Three major and interrelated health care challenges face our nation today.

1. We must guarantee access to necessary health care services for all Americans.
2. We must control health care costs.
3. We must strengthen our delivery system to ensure that care is appropriate and of high quality.

It is the position of the Academy that none of these three goals can be achieved in isolation. Access to health insurance and health services is not meaningful if not affordable. Health spending cannot be controlled in the face of cost shifting that results when millions of uninsured and underinsured Americans must seek uncompensated care. Meaningful access and cost control will not be achieved until we improve our delivery system, in particular, by correcting the severe shortage of generalist physicians trained to provide the coordinated, managed care that all Americans need.

This year by a unanimous vote, the AAFP Board of Directors adopted "Rx For Health: The Family Physicians' Access Plan." Our plan addresses all three of the major health care challenges with a comprehensive strategy to guarantee access to health care, ensure affordability, and promote the appropriateness and quality of health care services. "Rx For Health" is a document in progress. We acknowledge that additional issues related to health system reform require further study and recommendations. We are in the process of seeking cost estimates and developing specific financing options to ensure that our proposal would not add to the federal deficit. We also intend to make future recommendations concerning access to appropriate and affordable long term care services. A copy of the entire "Rx For Health" document is attached. Today, however, I will focus on the specific cost containment strategies.

AAFP STRATEGY FOR COST CONTAINMENT

In light of the topic of today's hearing, the Academy urges the Committee's serious consideration of the cost containment strategy outlined in "Rx For Health." "Rx For Health" includes many proposals for containing health care costs, including medical malpractice reform, consolidation of paperwork and administrative expenses, and uniform payment systems. An important element of our cost containment strategy involves the creation of a National Health Commission with authority to establish a global budget for aggregate health care spending. We believe our proposals draw on the strengths of many different reform plans while protecting the interests of patients, providers and all other players in our health care system.

First, by establishing a framework for global health care budgeting, the AAFP "Rx For Health" plan offers dependable cost containment. American families, employers and taxpayers can no longer wait for the promise of affordable health care. They need a mechanism to set and enforce national targets for health care spending. Under our proposal, a National Health Commission would be established to determine national cost containment objectives and coordinate and reinforce private and public efforts to achieve those Objectives. Individual health plans would implement the global spending limits by negotiating managed care arrangements and payment levels with providers. Flexibility to conduct negotiations would be retained in plans whose costs remain within limits established by the National Health Commission. However, the Commission would have authority to enforce spending goals, if necessary, by limiting provider payment increases or otherwise controlling spending under private and public plans failing to adequately contain costs.

Second, while establishing a mechanism for setting overall national limits on the rate of health care spending growth, "Rx For Health" proposes to achieve cost containment goals by encouraging the use of creative strategies to address uneven cost escalation at the state and local health plan level. Portland Oregon is not like Portland Maine. Different factors contribute to health care spending in different communities at different times. We must give health plans and providers the opportunity to negotiate financial incentives, utilization controls, peer review arrangements, and other managed care practices that make sense in light of their local needs and practices.

Third, our plan builds on the concepts of the Medicare Volume Performance Standard (MVPS) program, with which physicians and the Congress are just now

becoming familiar. The nation's goals for annual health care spending growth would be expressed in terms of performance standards. Performance standard rates of growth would be established for aggregate health care spending growth, as well as for each major component of health care spending, to include for example, hospital, physician evaluation and management services, surgery, imaging, medical procedures, laboratory services and prescription drugs. Goals would be established and performance evaluated based in an informed process that takes into account not only costs but detailed data on why costs change and how access and quality may be affected.

Fourth, "Rx For Health" requires that the National Health Commission include representatives of all the participants in our health care system—patients, providers, insurers, employers, and so on. This will permit a variety of needs and interests to be taken into account and fairly balanced as societal health care spending goals are determined.

Finally, the cost containment strategy outlined in "Rx For Health" assumes the eventual achievement of a generalist-oriented health care delivery system. The plan requires enrollees to have a Personal Physician, who is a family physician/general practitioner, general internist, or general pediatrician. Services rendered by the patient's Personal Physician would not be subject to a deductible but would be subject to 20 percent coinsurance (except for prenatal care, well baby and well child care and childhood immunizations which would require no patient cost sharing). Services rendered by physicians other than the patient's Personal Physician without referral from the Personal Physician would be subject to a 20 percent coinsurance penalty. The plan includes strategies to move toward a physician supply in which at least half of all physicians are generalists. Our present, overly-specialized medical corps is a prime factor contributing to rising health care costs. Until we address this problem, effective cast containment can be neither legislated nor negotiated.

IMPORTANCE OF GENERALIST PHYSICIANS

For decades, distinguished institutions and organizations, including the Institute of Medicine, the American Medical Association, the General Accounting Office, the Council on Graduate Medical Education and the Association of American Medical Colleges have called for a medical specialty distribution with at least 50 percent generalists. A generalist physician is trained to work primarily in an ambulatory setting with previously-undiagnosed patients to promote health and treat disease and injury. In most (85 percent) cases well trained generalists will resolve patients' medical problems themselves. When necessary the generalist physician will refer patients to the appropriate consulting subspecialist. In all cases the generalist physician role includes the coordination of care for the whole patient on an ongoing basis to assure continuity, quality and cost effectiveness.

The logic of a delivery system based on generalist physicians may seem intuitive. Many of us can describe the experience of a friend or relative who "ping-ponged" through the subspecialist system and an expensive battery of tests and procedures in search of a diagnosis and appropriate treatment. This can and does occur when patients with undiagnosed health conditions seek care from subspecialists trained to identify and treat problems associated with a single disease or organ system. A well trained generalist physician offers a more appropriate entry into the medical system, as well as a source of ongoing care.

Intuition notwithstanding, many academic studies have documented the benefits of a medical corps built on a foundation of at least 50 percent generalists.[1] Our fellow nations rely on such physician specialty distributions and enjoy lower costs, better health outcomes and higher levels of patient satisfaction. In the U.S., group and staff model HMOs recruit generalists to achieve a 50/50 specialty mix.

Strong evidence calls for reforms to redirect the billions of federal dollars now supporting predoctoral and graduate medical education in order to encourage the training of more family physicians, general internists, and general pediatricians.

---

[1] See Barbara Starfield, "Primary Care and Health, A Cross-National Comparison," *Journal of the American Medical Association*, October 23/30, 1991. This study compares ten nations on the basis of their primary care health delivery systems and finds better health outcomes and higher public satisfaction in countries where a generalist/primary care model of health care delivery predominates.

See also Sheldon Greenfield, M.D., et.al., "Variations in Resource Utilization Among Medical Specialties and Systems of Care," *Journal of the American Medical Association*, March 25, 1992. This study examines treatment patterns across medical specialties and finds generalists to be more cost effective.

Finally see Avi Dor and John Holahan, "Urban-Rural Differences in Medicare Physician Expenditures," *Inquiry*, Winter 1990. This study finds lower costs associated with a higher proportion of family and general physicians.

The Academy plan includes specific recommendations addressing Medicare graduate medical education payment policies, incentives for training generalists utilizing the indirect portion of extramural research grants from the National Institutes of Health, and federal medical student loan programs favoring those student who pursue careers as generalist physicians.

These proposals follow the flow of some $10 billion federal dollars annually subsidizing predoctoral and graduate medical education and suggest how this sizeable taxpayer support should be leveraged to encourage medical schools and residency programs to promote training of generalist physicians. Without an explicit national policy, backed by strong financial incentives, to correct the shortage of generalist physicians, the surplus of subspecialists, and its concomitant problems for access, cost and quality will persist.

STRATEGIES FOR ACTION

Family physicians understand that comprehensive health care reform may not be enacted all at once. Change may be pursued in increments as our nation struggles for consensus on broader reform. If an incremental strategy is ultimately pursued the AAFP strongly urges that each component be consistent with the comprehensive strategy outlined in "Rx For Health."

One necessary initial step in any reform approach—comprehensive or incremental—must be to promote the training of more generalist physicians. The medical training "pipeline" for family physicians is as long as seven years. Many medical schools today do not have departments of family medicine; nor are students exposed to family practice through required clerkships. Immediate steps must be taken to reverse the decline in training generalists. Given this Committee's jurisdiction, the Academy urges careful consideration of our proposals for Medicare reimbursement of graduate medical education. Promoting training of generalist physicians in appropriate settings should be an early and urgent priority.

The Academy also encourages other reform proposals to be viewed in the context of our recommendations for increasing generalist training. For example many advocates for health reform today emphasize the promise of managed care. Given our physician specialty distribution, one must wonder who will be qualified and available to manage care. Congress cannot begin soon enough to answer this question.

In conclusion, Mr. Chairman, I would restate the Academy's commitment to work with you and this Committee to achieve universal access to affordable, high quality health care.

Attachment.

Rx for Health: the Family Physicians' Access Plan

A proposal by the
American Academy of Family Physicians

Summary of Major Provisions

Universal Health Insurance Coverage

Universal health insurance coverage must be achieved primarily through employer based plans, in combination with state-sponsored public plans which would replace Medicaid and provide coverage for eligible low income individuals and employees of small businesses.

Physician Specialty Distribution

A common cause of all our nation's health system problems — lack of access to appropriate health care, rising health costs, concerns about quality — is the severe shortage of well trained generalist physicians. Our overly specialized medical corps (with less than 13 percent general and family physicians) cannot manage care appropriately and tends to prescribe expensive subspecialty services unnecessarily. The foundation of any health reform strategy must include coordinated changes to achieve a physician specialty mix with at least 50 percent generalist physicians, at least half of whom are family physicians.

Basic Health Benefits

Federal law must define a basic health benefits package for all health plans which would assure comprehensive coverage while promoting cost effective delivery of care.

Cost Containment

An effective cost containment strategy must be adopted to assure affordability of insurance. This strategy must include private and public health plan intitiatives to better manage care, tort reforms, limits on administrative expenses, and a uniform payment system for providers. In addition, a National Health Commission must have authority to establish a global budget for health care spending, and to enforce spending goals, if necessary, by limiting provider payment increases or otherwise controlling expenditures under private and public health plans.

Quality

Quality of care must be protected and enhanced through a variety of reforms and research efforts.

Insurance Reform

Private health insurance reforms must assure all health plans are guaranteed issue, guaranteed renewable, and community rated, and must protect the portability of basic health coverage.

Financing

The AAFP plan must not increase the federal deficit. The cost of reforms will be financed by resource reallocation and modified taxation strategies.

AAFP Position Statement on Access to Health Care for the Uninsured and Strengthening the U.S. Health Care System

Introduction

In 1989, the American Academy of Family Physicians adopted a position in support of reform of our health care system to achieve universal access to basic health care services. The Academy remains committed to this fundamental reform. Since he , the number of uninsured Americans has grown and rising health costs have threatened access further. The Academy has been involved in the changing public policy debate of health care reform solutions. This document represents an evolution in our 1989 health care plan. It refines many elements of our earlier health care plan; it specifically addresses the problem of rising health care costs; and it underscores the need to address underlying problems of an overspecialized physician corps in order to achieve a more appropriate system of health care delivery grounded in primary care.

As the national policy debate on health care reform proceeds, the Academy will continue its active involvement and will consider further evolution in our proposals for reform. In addition, the Academy is in the process of developing more detailed proposals to finance universal access to health insurance as well as recommendations for ensuring access to long term care.

Statement of the Problem

During the 1980s and the early 1990s, there has been a dramatic increase in the number of Americans who are without health insurance. Estimates place the number of uninsured Americans at 38 million. Additional tens of millions are thought to be underinsured. While public opinion polls repeatedly have indicated widespread agreement that everyone has a right to adequate health care, those same polls evidence little enthusiasm for improving access through increased taxes. The dilemma, then, is how to address a societal problem of significant proportions — the lack of access to health care for millions of Americans — given our finite financial resources and a reluctance among both policy makers and the public to increase taxes to provide insurance coverage. Despite this dilemma the AAFP believes the issue of access to health care for the uninsured must be addressed as one of this Nation's highest priorities.

Affordability of health care is a major concern for all Americans. Although the U.S. health care system at its technologic best is the envy of the wo l, it has fallen victim to structural and financial barriers that hinder access to primary medical care and detract from the appropriateness and cost effectiveness of health care services. A key structural barrier is that less than 13 percent of American

physicians are family physicians/general practitioners. By contrast in most Western nations at least 50 percent of physicians are family physicians or other generalists. An over-specialized medical corps is not trained to manage health care services and tends to promote overuse of expensive medical procedures and technology. Furthermore, our systems of reimbursing health care services create financial disincentives to the appropriate management of health care based on a primary care model.

While most insured Americans receive health coverage through employment based plans, fully 3/4 of the uninsured are employed or dependents of people who have jobs. Another significant segment of the uninsured population are the poor and near poor, who are not covered by Medicaid or other means tested public health insurance programs.

Small businesses, which employ a majority of uninsured workers, face particular difficulties in obtaining group health insurance coverage. Risk selection practices prevalent in the private, small group health insurance market today present an especially inappropriate barrier to obtaining heal coverage. It is not uncommon for small employers to be denied coverage at any price due to the nature of their business (e.g., high risk, seasonal employment, health related employment, etc.) or due to a preexisting health condition of an employee. Insured small employers often have difficulty renewing coverage at an affordable rate once a member of the group has incurred an expensive claim. Furthermore, many small employers just entering business or with small profit margins find that the price of employee health benefits — risk selection practices notwithstanding — is a major barrier to access to coverage. For these reasons, small employers who otherwise desire to provide group health coverage for their workers and families are unable to do so without targeted assistance.

The Medicaid program conditions beneficiary eligibility on requirements that vary significantly from state to state. Much of the variability is based on different state definitions of eligibility for cash assistance. Less than half of those below the federal poverty level qualify for Medicaid benefits, and the scope of benefits also varies from state to state. Because Medicaid payments for services are substantially discounted, a two-tiered system has developed under which Medicaid patients' choice of providers are limited. Many do not have access to "mainstream" medical care. For these reasons, the Medicaid program does not present a viable mechanism for addressing the problem of access for the uninsured.

To summarize, our nation's health care system faces interrelated problems requiring systemic reform. Such reform must specifically and meaningfully address the issues of providing universal health insurance coverage, controlling rising health care costs, ensuring an adequate supply of appropriately trained health professionals, and maintaining quality of care.

Strategies for Solutions

is the position of the Academy that the issue of universal access to affordable, appropriate health care can best be addressed through a system that is based primarily in the private sector. However, this system must also include a public sector insurance component for people not otherwise covered, and it must include significant structural and financial reforms to promote the delivery of appropriate,

cost effective health care services. Such a system should be based on the concept that all Americans have ready access to primary care services as well as appropriate access to more elaborate medical technologies. Furthermore, a reformed health care system should not be so complex as to undermine the ability of patients, providers, and insurers to understand it and operate effectively within it.

Under our approach, which would be phased in over time, all employers would be required to provide insurance coverage for basic health benefits (see page 13) for their full-time employees and their dependents. Employees would be required to participate in their job-based health plans. Individuals not covered by employer provided insurance would be covered under new, publicly-sponsored health insurance programs. To ensure the availability of basic health care services and the appropriate utilization of more elaborate technologic services, various reforms would be adopted to increase the supply of family physicians and other generalist physicians relative to other medical specialists. To ensure that health care would be more affordable, health care financing reforms and other measures to promote administrative efficiency would be adopted. Finally, reforms would be adopted to control the cost of health care services, but without sacrificing the quality of services delivered.

Recommendations

Consistent with the overall objective of providing universal access to appropriate, affordable health care, through a combined private sector/public sector effort, the Academy supports the following principles:

I. Employer Provided Coverage

(a) All employers would be required to provide health insurance covering the federally established basic benefit package for employees who work more than 17.5 hours per week and their dependents.

(b) Small businesses with fewer than 25 employees would be eligible to purchase health insurance from a state established public program (see II.(b), page 4), with the cost of such insurance based on a percentage of the employer's payroll. The payroll tax rate would be set to ensure a fair balance between private and publicly sponsored coverage for employees.

(c) Under the employer mandated coverage, the employer would be required to pay no less than a statutorily defined percentage of the employees' insurance premiums. Employees would be responsible for their portion of the insurance premium and for reasonable cost sharing.

(d) Federal standards would be established for qualified employer group health insurance policies to ensure adequate access to basic health care services necessary to prevent, diagnose or treat disease and injury. The federal standards for coverage also would ensure protection from financial catastrophe for covered individuals. Patient cost sharing would be structured to promote cost-conscious use of health services and to encourage early and unhindered access to preventive and other primary care services. In addition, cost sharing would

discourage inappropriate use of expensive subspecialty services by patients without referral from their Personal Physician (see V.(b), page 7).

These federal health benefits standards (described in detail on page 13) would preempt state health benefit mandates for all employment based health plans.

II. Publicly Sponsored Coverage

(a) Each state would establish a public program that would replace Medicaid for covered services (described on page 13) and that would contract with private insurance carriers to provide health coverage meeting the same minimum standards required for employer sponsored plans. The state established program would be available to small businesses (see I.(b) page 3) and to those individuals not otherwise covered by employer sponsored plans or Medicare (see II.(b) below).

(b) Individuals not covered under employer plans would be required to enroll in the public program in their state. Uninsured persons failing to enroll would be deemed enrolled in the public program at the time they seek health care services. Financial assistance for premiums and cost sharing under the public plan would be available based on uniform federal guidelines. Persons with incomes at or below the federal poverty level would be wholly subsidized for their premium and cost sharing expenses. Individuals between 100 and 200 percent of poverty would be eligible for subsidies based on a sliding scale. Persons with incomes above 200% of poverty would pay the full premium.

(c) Payment for services under the public program would be at par with Medicare payment and would be established according to Medicare payment methods, including a resource-based relative value scale for physician services. The cost of the public programs (including the cost of subsidies for small employers and low income persons) would be financed through a system of state funds and federal matching grants with poorer states eligible for greater financial assistance.

(d) The new public program would not replace or change other public programs such as Medicare, military and veteran health programs, Worker's Compensation, etc.

III. Insurance Reform

(a) The private health insurance market would be reformed to achieve uniform coverage for basic health services, portability in health insurance coverage, stability in health insurance premiums, and administrative cost savings. Insurance reforms would apply to all health plans — those covering only basic services as well as those covering additional benefits.

(b) All health insurance carriers would be required to offer a plan covering only the federally established basic benefits package. In addition, health insurers would be permitted to offer plans with coverage in excess of the basic health benefits. Insurers would have to make all plans available under traditional indemnity and managed care options.

(c) All health insurance plans would be guaranteed issue and guaranteed renewable. No insurers would be permitted to deny, discontinue or condition coverage under any health plan based on the health status or claims history of the person or group applying for coverage. In addition, to ensure portability of coverage, no insurers would be permitted to exclude coverage under any health plan for pre-existing health conditions.

(d) All health insurance plan premiums would be determined according to community rating within defined geographic areas.

(e) To minimize the administrative expenses of health insurance and health services, all insurers would be required to use a uniform billing system and claim form, permit electronic submission and payment of claims, and meet minimum standards for timely reimbursement of providers.

IV. Physician Supply

(a) Congress must adopt national policies to ensure that, over time, at least one-half of all physicians in the U.S. are in general medical specialties (family medicine, general internal medicine, and general pediatrics) and, further, that at least one-half of all generalist physicians are family physicians. To achieve this goal the following reforms would be implemented.

(b) Federal financial incentives that discourage medical schools from emphasizing the training of generalist physicians would be reversed. Billions of dollars in biomedical research grants from the National Institutes of Health (NIH) constitute a significant revenue source for many medical schools. Competition for such grants encourages schools to divert resources and prestige to revenue generating departments in the medical subspecialties, while de-emphasizing departments of family medicine. This is evidenced by the fact that among the ten leading recipients of NIH competitive medical research grants in 1990, on average, only 7.3 percent of graduates entered residency training in family practice.

Financial incentives would be realigned to encourage medical schools to increase the priority given to training in family medicine, general internal medicine, and general pediatrics.

- Receipt of the indirect portion of extramural research grants from the National Institutes of Health (NIH) would be conditioned on the extent to which medical schools graduate a minimum proportion of students who become generalist physicians upon completion of residency training. The indirect portion of grants is paid to the medical school, not the

researcher, to compensate the institution for a portion of its overhead costs. For a specified interval, medical schools failing to achieve the minimum proportion should be exempted from reductions in the indirect payments if the school meets certain criteria related to encouraging more students to select generalist training. Criteria would include selective admission procedures, a formalized department of family medicine, and a required family practice clerkship of at least six weeks duration by no later than the third year of medical school.

- These requirements should be carefully designed and applied so that the direct portion of biomedical research grants and individual research efforts and agendas are not compromised.

- Federal matching grants to states for the public program would contain incentives to encourage medical schools to increase the absolute and relative numbers of graduates entering residency programs in family medicine, general internal medicine, and general pediatrics.

(c) Federal financial support for graduate medical education (GME) also would be realigned to encourage residency training of generalist physicians in more appropriate ambulatory settings.

- Medicare reimbursement for the costs of GME would be restricted to only the first three years of residency training;

- GME payment formulas would assign a greater weight to family practice and other primary care residencies;

- HMOs, clinics, and physician practices would be eligible for Medicare GME payments;

- Medicare GME payments would be restricted only to the training of residents in specialties in documented undersupply.

(d) Finally, federal financial incentives should encourage medical students and residents to enter generalist specialties and should encourage generalist physicians to remain in practice, especially in medically underserved areas. Accordingly,

- The time for repayment of medical school student loans would be extended for residents who enter practice in family medicine, general pediatrics, and general internal medicine. Additionally, interest payments on medical school student loans would be publicly subsidized during residency training in those specialties.

- Physicians practicing family medicine, general pediatrics, and general internal medicine in medically underserved areas would be eligible for partial or entire student loan forgiveness.

V. Cost Containment

(a) A multi-faceted approach to cost containment must permit competition at the state and local plan level to pursue creative, negotiated solutions, while assuring that national goals for affordable health care services are met.

(b) All private and public health plans would seek to control costs and to enhance the quality and appropriateness of health services using a primary care model. Toward this end all basic health plans would:

- require enrollees to have a Personal Physician, who is a family physician/general practitioner, general internist, or general pediatrician, and who will serve as their source of regular and ongoing medical care. A requirement that the Personal Physician be in one of the generalist specialties should be phased in as the specialty maldistribution of physicians is corrected (for example, during the transition period, an obstetrician/gynecologist could serve as a Personal Physician;)

- incorporate patient cost sharing requirements to promote cost effective preventive services and to discourage inappropriate use of subspecialist services. These cost sharing requirements would include:

  - all covered services, except as specified immediately below, would be subject to a deductible of $250 per person, or $500 per family, and to 20 percent coinsurance;

  - most periodic screening and evaluation and preventive care services would not be subject to a deductible, but would be subject to 20 percent coinsurance;

  - prenatal and well baby/child services, including childhood immunizations, would not be subject to either a deductible or coinsurance;

  - services rendered by the patient's Personal Physician would not be subject to a deductible, but would be subject to 20 percent coinsurance;

  - non-emergency services rendered by physicians other than the patient's Personal Physician without referral from the Personal Physician, would be subject to an additional 20 percent coinsurance (for a total of 40 percent.) This requirement would be phased in as the medical specialty distribution is adjusted;

  - total patient cost sharing (deductibles and coinsurance) would be limited to $1,500 per year per individual and $3,000 per year per family. However, the 20 percent coinsurance penalty for self-referred services would not apply toward or be limited by this out of pocket limit;

- incorporate established, outcomes-based clinical policies into plan practices;

- reimburse health providers using uniform payment methods, including a prospective payment system for hospitals and a resource-based relative value fee schedule for physician services;

- negotiate with providers to establish Component Performance Standards (as described in V.(e), below), including fee schedule conversion factors and appropriate utilization controls, that would achieve nationally established performance standards for aggregate health care spending growth.

(c) Federal standards would be developed to replace state laws regulating managed care and utilization review programs. At a minimum federal standards would

- encourage the development of financial incentives to promote appropriate referrals and cost effective delivery of health services;

- ensure that these financial incentives are not structured in such a way as to threaten the quality of care;

- ensure that managed care plans have a sufficient number and distribution of providers (by specialty and by geographic location) to assure enrollees of the timely availability of all covered services.

(d) Medical liability reform would be implemented to promote both the affordability and appropriateness of health care by limiting the tendency to provide "defensive medicine." Medical liability reform would provide for

- alternative dispute resolution systems, such as binding, fault-based arbitration systems;

- malpractice tort reforms, including limits on payments for "noneconomic damages," limits on attorneys' contingency fees, elimination of joint and several liability, reductions in awards by the amount of compensation from collateral sources, and structured payment schedules to replace lump-sum awards;

- use of federal funds to establish a risk retention group that would provide affordable liability protection to health care professionals practicing in community and migrant health centers; and

- strengthening of state licensing and disciplinary agencies to provide prompt remedial and/or punitive action when such action is warranted.

(e) A National Health Commission would be established for the purposes of determining national cost containment objectives and coordinating and reinforcing private and public efforts to achieve those objectives. State and local health plans would retain the ability to develop and implement specific cost containment mechanisms within the context of the broad objectives established by the National Health Commission (see V.(a), page 7). The

National Health Commission would be comprised of members representing large employers, small employers, patients, private insurers, states, and major providers of health care services (e.g., hospital, physician, prescription drug, etc.) At least half of the representatives of physicians on the Commission would be in the generalist specialties, and at least one of the generalist physicians would be a family physician. Duties of the Commission would include:

- collecting and disseminating data including profiling data and measures of the volume and intensity of health care services and factors that affect volume and intensity. In this regard, a high priority for the Commission would be to promote the development of measures of factors (such as epidemiological trends, poverty, etc.) that affect health care spending and that might warrant adjustments or exceptions in evaluating the success of health plans at controlling health costs;

- developing a uniform claims processing system to promote administrative efficiency and prompt payment for services by all health plans;

- establishing a national budget for aggregate health care spending. The global budget would be expressed in terms of an "Aggregate Performance Standard" rate of annual growth in spending for health care services. For example, the global budget for aggregate health care spending in 1995 would be the amount of aggregate health care spending in 1994 increased by the Aggregate Performance Standard rate of growth for 1995. The Aggregate Performance Standard would be established by the Commission annually;

- evaluating and enforcing compliance of state and local health plans with the national budget for health care spending and the Aggregate Performance Standard rate of growth;

- establishing performance standard rates of growth for each major component of health care spending (i.e., hospital, skilled and intermediate care nursing facilities, physician evaluation and management services, surgery, imaging, medical procedures, laboratory services, prescription drugs.) In general, these "Component Performance Standards" would be advisory. However, the Commission could direct a health plan to follow the nationally established Component Performance Standards to limit plan expenditures in a year when aggregate health care spending under that plan exceeds the rate of growth permitted under the Aggregate Performance Standard (see V.(f), page 10). Component Performance Standards would be established by the Commission annually;

- providing technical assistance to plans in order to

  - analyze data to determine the factors contributing to increased health care spending within each Component Performance Standard; and

  - develop remedial responses (such as targeted utilization review, prior authorization requirements, and the development of specific clinical practice parameters) to address those factors contributing to excessive cost increases.

(f) The relationship between state and private health plans to the national performance standard process would be as follows:

- The Aggregate Performance Standard for health care spending growth would be binding for all state and private health plans. To illustrate, if the Commission determines that aggregate health care spending should grow by no more than ten percent in a given year all health plans must strive to limit growth in their per capita health costs (with adjustments for the age of plan enrollees) to ten percent.

- Health plans and their participating providers would be free to negotiate their own Component Performance Standards in order to meet the national Aggregate Performance Standard. For example, a health plan potentially could meet the Aggregate Performance Standard, even though its own Component Performance Standards differed from those set by the Commission, if that plan successfully employed a primary care model to manage care, reduce unnecessary hospitalization, and promote a more appropriate mix of health care services. In addition, a plan meeting the national Aggregate Performance Standard for spending growth could negotiate higher conversion factors or bonus payment arrangements with its providers.

- However, if a health plan's aggregate spending growth exceeds the national Aggregate Performance Standard, the ability to negotiate independently Component Performance Standards and fee increases with providers would be constrained. In such a case, increases in provider fees could be limited according to their performance under their respective nationally established Component Performance Standards. Similar to the Medicare Volume Performance Standard program, the national performance standard process would include a stop loss to limit reductions in provider payments in a year subsequent to spending in excess of the performance standard.

(g) Evaluation of health plans' performance would take into account differences in the age of plan enrollees. In addition, as data become available the National Health Commission would provide for an exceptions process for health plans that can demonstrate cost increases attributable to "uncontrollable" factors such as unfavorable risk selection among plan enrollees or epidemiological changes.

VI. Quality of Care

(a) Ensuring high quality of health care services must be the highest priority of any health care reform proposal.

(b) Often, the goals of quality and affordability will be consistent. In particular, reforms which promote the primary care model of health care delivery will enhance the quality of care by reducing unnecessary medical and surgical procedures, which can increase patient risk.

(c) In addition, affirmative steps to promote the quality of care must be undertaken. At a minimum,

- health plans should develop risk management/quality assurance programs with required provider participation;
- established outcomes-based clinical practice parameters should be incorporated into health plan quality assurance programs;
- data collected from uniform claims processing systems should be used to profile physician medical practices. Profiling information should be used to educate physicians about their practice patterns and encourage improvements in quality of care.

(d) At no time should the quality of care be sacrificed in the name of cost containment. To protect against this, national and plan-specific performance standard programs must consider evidence of quality concerns in the setting and evaluation of performance standards.

VII. Financing

(a) The Academy's public-private system of ensuring universal access to appropriate health care services should not add to the federal deficit. Every effort should be made to minimize the need for new taxes. However, additional federal expenditures that are necessary should be financed by resource reallocation and modified taxation strategies. The Academy is seeking estimates of the cost of its proposals and will develop more detailed recommendations on appropriate sources of revenues to finance this plan. In the meanwhile, we urge efforts to make taxpayers aware of the realistic cost of health care reform. As taxpayers, family physicians stand ready to pay their fair share for a more equitable and effective health care system.

Conclusion

The Academy believes that any accounting of the costs of this health reform plan should recognize the many offsetting economic benefits to society as a whole as well as to various private and public interests. Among these benefits:

(a) Universal health care coverage will significantly reduce cost shifting due to a heavy burden of uncompensated care, thereby achieving savings for sectors of the economy now bearing these costs.

(b) A generalist-based health care system will achieve savings through improved availability of primary care and through better managed, more appropriate, and more cost effective access to technological specialty services.

(c) Private health insurance reform will promote stability in premiums for small employers and streamline overhead expenses for small group insurers.

(d) Guaranteeing continuous, portable health coverage will eliminate secondary costs to society, including administrative costs of changing coverage and costs to the patient in terms of disruption in care.

(e) Uniform claims and payment policies will create administrative savings to insurers, providers, and premium payers.

(f) Inappropriate increases in health care spending will be limited through the use of volume performance standards.

(g) Medical liability reform will achieve savings through a reduction in costs due to "defensive medicine."

(h) Increases in health care costs to some employers who begin to provide health coverage pursuant to these reforms may be partially offset by savings to some other employers who have been providing health benefits and who have been paying a disproportionate share of the cost of dependents' health care coverage.

Implementation of the foregoing principles will result in a clearly-articulated national health policy with three sources of health insurance coverage — Medicare, employer-provided coverage, and a new publicly sponsored health plan system through which all of those not otherwise covered can be insured. In addition, these principles will promote the development of an adequate supply of properly trained primary care physicians who can ensure delivery of appropriate health care services in a cost efficient manner. Finally, health care reimbursement reforms, insurance reforms, benefit design reforms, and medical liability reforms will create incentives that complement a strengthened health care delivery system built on a primary care model. The American Academy of Family Physicians believes that with these programs in place, every American citizen will be assured of access to a broad range of essential, affordable health care services.

April, 1992

Basic Benefit Package

(Services not specifically listed would not be covered by the basic benefits package)

I. Immediate Access Services

- Prenatal Care
- Well baby and well child care
- Childhood immunizations

NOTE: Immediate access services would be covered under all health plans. No patient cost sharing (i.e., deductible or coinsurance) would be required for these.

II. Preferred Access Services

- Periodic evaluation and screening services, including routine physicals and cancer screening
- All outpatient services provided directly by the patient's Personal Physician

NOTE: Preferred access services would be covered under all health plans. They would not be subject to a deductible, but would be subject to 20 percent coinsurance.

III. Limited Access Services

- Inpatient and outpatient physician services (other than those provided by the patient's Personal Physician)
- Inpatient and outpatient hospital care
- Skilled and intermediate nursing facility care
- Laboratory and radiology services
- Inpatient and outpatient mental health services
- Treatment for substance abuse and addiction
- Inpatient and outpatient prescription drugs
- Medically necessary home health services
- Medically necessary medical equipment
- Routine dental care
- Routine vision care, including eyeglasses
- Routine hearing care, including hearing aids
- Rehabilitation services
- Hospice care

NOTE: Limited access services would be covered under all health plans. They would be subject to a deductible of $250 per person or $500 per family and to coinsurance of 20 percent. An additional 20 percent coinsurance penalty (for a total of 40 percent coinsurance) would be required when these services are rendered by physicians other than the patient's Personal Physician without referral from the Personal Physician. The 20 percent coinsurance penalty would not apply in medical emergencies.

Limits on Scope and Duration of Coverage

Coverage for mental health and substance abuse treatment would be subject to continuing review of medical necessity and appropriateness. Standards for continuing review would be developed by the Secretary of Health and Human Services in consultation with appropriate medical and other professional clinician organizations.

Periodic evaluation and screening services, preventive services, and routine dental, vision and hearing services would be subject to periodicity tables to be developed by the Secretary in consultation with the AAFP and other medical societies.

Catastrophic Protection

All patient cost sharing, except the 20 percent coinsurance penalty on self referral for subspecialty care, would be limited to $1,500 per individual and $3,000 per family per year.

PREPARED STATEMENT OF LANE KIRKLAND

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues for working people and their families.

At long last, this nation has reached an important milestone in the century-long debate over health care reform.

The AFL–CIO has long been on record in calling for federal legislation to assure all Americans access to essential health care services at a price they can afford. In this effort, we are now being joined by organized medicine and many in the business community who are offering their proposals for national health reform. This represents true progress toward resolution of the nation's health care crisis.

We believe that the time is right for Congress to take advantage of this growing consensus and to take the lead in fashioning an approach that will reduce health care inflation, expand access and improve the efficiency of the system.

It is crucial that you achieve these objectives before this crisis does further damage to American families, who have been called upon to absorb a major share of cost increases; American businesses that are attempting to do their fair share by providing health care coverage; and health care.

THE ECONOMIC IMPACT OF THE HEALTH CARE CRISIS

Increasingly, union members are concerned about preserving their negotiated health benefits. This concern is warranted. In recent years, the majority of labor-management disputes have been caused by the nation's health care crisis. When these disputes could not be settled at the bargaining table, all too often the workers found themselves permanently replaced when exercising their legal right to strike.

A recent study by the AFL–CIO Employee Benefits Department found that in 1990, health care was the major issue for 55 percent of striking workers. This study also confirmed the cold reality of the risk of job loss in a strike over health care. Last year a shocking 69 percent of all permanently replaced workers struck over health care benefits as the major issue.

This turmoil is not confined to organized labor. During the 1980s, the health care crisis further exacerbated the economic decline of the middle class. The average hourly wage, adjusted for inflation, dropped from $10.56 in 1980 to $10.03 in 1990. During the same period, health costs as a percent of payroll nearly doubled and expenditures for households increased from six percent to nine percent of gross earnings.

Health care costs are depleting the family income necessary for working Americans to maintain their homes, educate their children and achieve income security in retirement. If current trends continue, by the year 2000 one-third of total compensation will go to pay for health care at the expense of wages and other benefit improvements.

A similar trend is occurring nationally, as health care consumes a growing share of our economic resources. In 1980, health care programs accounted for 17 percent of domestic spending. Now that figure is 22 percent and by the middle of the decade, it will be 30 percent. Health care inflation is siphoning off valuable economic resources necessary for other national priorities, including education, infrastructure and research and development.

While public expenditures grow, beneficiaries of public programs continue to lose ground. Senior citizens pay more for health care than they did prior to passage of Medicare and 60 percent of those with incomes below the federal poverty level do not qualify for Medicaid.

In short, we are paying more for less. A nation that seeks to be competitive in the 21st century can no longer continue down this road. On a per capita basis, we spend 40 percent more than Canada, 90 percent more than Germany and 125 percent more than Japan. Rather than become mired in esoteric debates about competition vs. regulation, this committee and the Congress should recognize that the most costly solution would be to do nothing at all.

THE CASE FOR COMPREHENSIVE REFORM

Last Fall, the AFL–CIO commissioned a study by Lewin-ICF, Inc. to determine how much could be saved if Congress established a single cost containment program for all payers. They estimated that just a two percent reduction in the projected rate of growth in health inflation will save $165 billion (in 1990 dollars) by the end of the decade. Recently, the Prospective Payment Review Commission (PROPAC) issued a study that supported these conclusions. PROPAC estimated that if the Medicare payment rates were extended to private payers, there will be an immediate cost savings of $16 to $21 billion annually.

As part of its deliberative process, we would urge the Committee to compare the cost and performance of the U.S. health care system to those of our industrial partners. While these systems have unique structures and differ on numbers of payers, all of these countries have achieved universal access to health care benefits and effectively controlled costs by setting budget targets and paying providers uniform rates.

We urge the committee not to be distracted by the myths of rationing, excessive government bureaucracy and inferior quality that have long been advanced by those who oppose reform. Taken together, the health care systems throughout the industrial world provide conclusive evidence that it is possible to provide coverage to all Americans far more effectively and at an affordable cost.

The burden is on those that advocate market-based mechanisms to explain why we should continue with "voluntary efforts."

In comparison to our industrialized partners, the U.S. health care system fails the tests of fairness and equity. We also fail the test of efficiency, which is apparent to both consumers and providers who are frustrated with red tape and paperwork. Even those who support the current system can no longer defend the excessive overhead and administrative costs associated with our fragmented system.

In pursuing a "competitive" health care market, the U.S. has ended up with a system that operates on the principle of Social Darwinism. It punishes employers who provide health insurance to their workers by forcing them to, in effect, subsidize the health care of those who are employed by firms that seek a competitive advantage by refusing to provide such coverage. The system rewards purchasers with large groups or relatively young workers with short-term discounts, and it penalizes small employers and those with older, more experienced workers by forcing them to pay more for coverage. The system is replete with inefficiencies that have forced costs to rise sharply, and millions of Americans who are fortunate enough to be covered by health insurance have, as a result, suffered the financial burden of increased cost-shifting and reductions in benefits.

The view has long been held that, notwithstanding these structural flaws, the U.S. system provides better quality of care. But this too has proved to be another myth advanced by those who oppose change. While we do have more technology than other industrial countries, it is virtually impossible to defend the high rates of surgery and diagnostic tests, the relatively small attention paid to preventive care, including the immunization of our children, the lack of coordinated technology assessment and the duplication of equipment in our current system.

In short, our health care problems are urgent—and they are being exacerbated by our delay in acting on them.

AFL–CIO POLICY PROPOSAL

The labor movement is united in its pursuit of fundamental restructuring of the system and we have three essential goals: to contain health care inflation; to provide all Americans access to care; and to improve the quality of services.

All of the unions within the AFL–CIO support these goals. Attached to this testimony is a copy of our recent Convention resolution on health, which describes our prescription for reform. Some of our affiliates support the implementation as soon as possible of a single payer approach. But all of the unions believe that we need Congressional action now to address the health care crisis, and they support the Federation's efforts to get legislation that conforms to our principles enacted as soon as possible.

As a nation, we cannot hope to expand access or improve quality without controlling health care costs. The AFL–CIO has proposed a comprehensive strategy to bring health care inflation under control.

To achieve this objective, we have urged Congress to establish a national Commission composed of stakeholders in the system—labor, consumers, management, government and providers—to administer a single national cost containment program. The primary functions of such a Commission would be to conduct negotiations between health providers and purchasers of care on payment rates and other necessary measures to achieve these targets and to establish controls on capital costs.

Once payment rates are negotiated, they must apply to all payers, including government programs, to prevent cost-shifting. The Commission should use the methodology that has been implemented successfully under Medicare. Payments to hospitals should be on a DRG basis, with adjustments for facilities with special needs. Payments to physicians should be on the basis of a resource-based relative value schedule (RBRVS), with geographic adjustments as necessary.

We believe it is time to overhaul our costly administrative structure by establishing requirements for administrative intermediaries that would standardize claim

forms, develop a uniform health care information system and simplify paperwork. That means that Congress must establish federal regulations for insurers and managed care providers if we seek to improve the efficiency of the system.

Between those that argue government can not do anything and those that say government must do everything, there is considerable running room. The task before this Committee is to define the combination of public and private strategies that will make our system live up to its reputation as "the best in the world."

SMALL MARKET REFORM

In this Congress, I have testified before each of the House and Senate Committees that have jurisdiction over health care. I have stated repeatedly that the AFL–CIO is prepared to consider each and every proposal that meets our principles. We are not committed to any one plan. The one proposal that we reject out-of-hand is small market reform. No amount of political spin control will convince our members that this proposal moves us forward.

In our view, the term "small market reform" is not synonymous with health care reform, which must encompass comprehensive reforms in the organization of the health care system, payment of providers and delivery of care. The lessons of proposals already in place within certain states, is that small group market reform will not make health insurance accessible and affordable unless it is enacted as part of comprehensive package that controls costs and guarantees coverage.

There are important limitations in many of the small group market reform proposals:

- The reforms neither stop nor reduce the rising cost of health care, the major reason small businesses give for not providing health benefits.
- Reforms will raise costs for the majority of small employers and will not reduce overall premiums.
- The reform proposals would do nothing to guarantee that all individuals have coverage.
- Recent studies on subsidizing employment-based health insurance indicate that these subsidies have induced few small businesses to provide health benefits to their employees.
- During this time of budget cutbacks, state insurance departments may not have adequate resources to assure regulatory compliance with a comprehensive small business reform proposal.

OTHER PENDING LEGISLATION

The AFL–CIO is encouraged by the sheer numbers of bills that have been introduced to reform the health care system and the commitment on the part of Members of Congress to enact legislation in this Congress that will offer relief to families caught in the middle of the health care crisis.

The AFL–CIO has long advocated enactment of a social insurance national health insurance plan. S. 1446 introduced by Senator Kerrey and S. 2320 introduced by Senator Wellstone both call for restructuring the present system so that revenues are collected and then distributed through a single payment source. Working men and women are united in their belief that a single payer approach would be the most efficient mechanism for the systemic restructuring necessary to move us forward.

The legislation introduced recently by Senator Daschle, S. 2513, also is designed to capture the efficiency of a single collection mechanisms, but also to provide competition on the delivery side. This bill takes a fresh approach to the challenge of balancing the role of government and the private sector. While we believe that this proposal deserves an in-depth look, we are concerned about how much of the key decision making about the fundamental structure of the system is left to a Commission and the states. While we ourselves have advocated a Commission to develop reimbursement methodology, establish a strategic planning process for the system, and monitor the effect of systemic changes on Americans of all ages, we believe that the Congress cannot delegate the authority for defining basic benefits and establishing the financing arrangements.

We applaud the leadership offered by Senator Mitchell and his colleagues who introduced S. 1227 and we strongly support the amendments offered by the Labor and Human Resources Committee, making the cost containment provisions in that bill mandatory. The legislation also contains a unique feature to bring together supporters of single payer and limited payer approaches, allowing each state, within specific state budget targets, to determine how it desires to establish its cost containment system, including the option to adopt single payer.

In our view, it is imperative that any type of system, whether it be single or multiple payer, have the stability and uniformity of a national program. We are dubious of initiatives, which place the burden of developing, financing, and monitoring the system on the already hard-pressed states. Medicaid has taught us this important lesson.

We must also deflect attempts to delay national reform by encouraging state-based demonstrations. It seems ludicrous for the United States to take the position that demonstration projects are needed to help rally the public behind national reform. We can build on the vast experience that our country has acquired in running programs, such as Social Security and Medicare, that have been hugely successful in contributing to the well-being of the society as a whole.

CONCLUSION

We can reform the health care system—now—if we commit ourselves to get on with the job. To advocate anything less is to accept the inevitable chaos in which the nation's resources continue to be misapplied and drawn into the black hole of uncontrollable costs.

No combination of voluntary efforts will be enough to solve the deep-rooted problems of rising costs, diminishing access and uneven quality. It is time for all members of Congress to exercise the type of leadership the American people deserve from their elected officials. It is time for Congress to take a hard look at the effects of the health care crisis on their constituents and time to develop and enact the comprehensive health care reforms that working men and women so desperately need.

RESPONSE OF MR. KIRKLAND TO A QUESTION SUBMITTED BY SENATOR WELLSTONE

Question. Regarding Mr. Enthoven's proposal for managed competition, please elaborate on examples you referred to in which competing plans with the same benefits have been offered to employees, but did not avoid shifting of costs and risks, or cost increases?

Answer. In pursuing a competitive health care market, the U.S. instead has a system that operates on the concept of Social Darwinism. It punishes employers who provide insurance to their workers by forcing them to, in effect, subsidize the health care of those who are employed by firms that seek a competitive advantage by refusing to provide such coverage.

The fact that competitive forces in the health care market have failed is undeniable. According to the Congressional Budget Office ". . . if competition were an effective strategy, the rate of increase in health care costs in the United States would have declined during the 1980s, particularly in areas that have become more highly competitive."

According to the Group Health Association of America, from 1989 to 1990, on average, HMO premiums increased 17 percent for single contracts and 18.4 percent for families. The 1991 growth was about the same as experienced under non-managed, fee for service plans about double the overall medical inflation rate.

Despite initial hopes, case management strategies have not contained costs as expected. According to a *Business and Health* survey of business executives in 1991, only 30 percent believe case management has been very effective in containing costs, down from 46 percent in 1990. Only two in 10 executives were "very confident" that managed care will be able to control U.S. health care cost without government involvement.

Some have proposed to limit the amount that any business can deduct for health insurance to the lowest cost plan offered. The intent is to entice businesses to offer only the minimum plan available. Unfortunately, low cost plans are not always the most efficient providers of care. Absent effective initiatives to contain costs, tax caps will only penalize employers in high cost markets, high-risk industries and in plans with older workers or victims of chronic disease.

If you have any further questions, or need additional information, please do not hesitate to call.

PREPARED STATEMENT OF GREG LAU

Good morning, Mr. Chairman and Members of the Committee. My name is Greg Lau, and I am an Assistant Treasurer for the General Motors Corporation, with responsibilities that include health care. Today's hearing focuses on an issue of crucial importance to General Motors and to the international competitiveness of U.S. business—that is, the need to curb the alarming rate of growth of health care costs in this country. At GM, health care expenses are growing faster than any other labor,

capital or material cost incurred in the production of a motor vehicle, and these growing outlays for health care erode our ability to fund other pressing corporate objectives.

By way of background, GM is the largest private purchaser of health care in the U.S., spending almost $3.4 billion in 1991—or $929 per vehicle—and providing coverage to about 1.8 million persons. Not only are our absolute expenditures for health care enormous, but they also place us at a serious disadvantage relative to Japanese transplants who have lower costs because of their younger workforces and a virtual absence of retirees. The spiralling increase in health care costs places a special burden on mature industries like ours that have extensive responsibilities to employees and retirees.

My objective today is to share some of GM's experiences in the hope of illustrating the kinds of cost containment actions that may be required at the national level. GM's health care costs, on a per person basis, continue to rise at an average rate of about 11–12% a year. Although that rate is lower than the 15–16% average rates for all manufacturers, it is still significantly higher than the rate of increase in the Consumer and Producer Price Indexes. Clearly, a more aggressive and comprehensive approach to health care cost containment is needed.

In the mid-eighties, GM undertook a series of initiatives to exert more control on its rising health care costs. Two actions that proved instrumental in reducing GM's administrative and overhead costs for health care were the decisions to move to a self-funded basis and to establish a nationwide claims and eligibility system. The standardization of the claims process also provides the capability to perform on-line edits of payments that helps us prevent fraud and duplication. However, trimming administrative costs is not a sufficient strategy to control the rising rate of health care costs. Rather, the key to controlling health care costs lies in managing the use of services—without such controls, long run cost containment is unlikely. Perhaps the most significant of GM's costs containment initiatives was the redesign of our benefit plans to expand "managed care." By design, "managed care" programs are intended to control the use of services by providing incentives for both providers and consumers to reduce unnecessary or ineffective services. We added a pre-determination process to our traditional fee-for-service program and offered Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs) as coverage alternatives. Also, salaried employees who choose to remain with the traditional program are now subject to cost-sharing requirements that also reduce GM's cost and utilization.

Our experience with these programs has been mixed. GM does not require individuals to join HMOs or PPOs. These options attract enrollment through expanded benefits; however, in some cases the positive impacts of utilization controls have been insufficient to cover the cost of the added benefits.

In large part, the effectiveness of PPOs depend on their ability to identify and exclude providers from the panel who do not provide quality care in the most cost-effective fashion. However, we have found that highly selective panels are difficult to achieve, in part because of provider relations issues, employee concerns about provider selection, and the reluctance of program administrators to address this objective aggressively. In some cases, these issues have even given impetus to state-level anti-managed care—or so-called "freedom of choice" legislation—which we strongly oppose.

Managed care can work. One of our more notable success stories—both in terms of quality and cost—involves our substance abuse coverage. GM, together with its unions, conducted pilot studies that identified serious concerns about the quality of substance abuse care being received, as well as the spiralling costs. In response, we implemented a national pre-determination program, appointed local case managers, and established a "closed panel" of providers who met basic quality and cost-effectiveness criteria. Subsequently, through close monitoring of data, we instituted further changes in coverage that, in effect, placed sanctions on our employees who did not seek care when needed or complete the planned course of treatment.

This integrated approach to managed care, with incentives for individuals and providers, worked. The quality of substance abuse treatment improved significantly and costs decreased dramatically. Further, the acceptance of these changes by our covered population has been positive. Building upon this success, we are now treating our mental health coverage in the same way.

From our experience, we believe it is critical to build managed care principles into the design of any health care program. Careful attention needs to be given to basic benefit design to prevent unnecessary utilization and avoid coverage of marginal value—including overutilization of technology. Appropriate cost-sharing should be an integral component of any plan, because of its proven effectiveness in promoting judicious consumption of health care services. Clinically-sound guidelines for the

provision and use of services should be established in advance, along with objective criteria for selection of high-quality cost-effective service providers. In addition, to support managed care efforts, more work needs to be done to establish effective outcome measures and practice guidelines.

In summary, GM's experience with managed care suggests specific controls on service use and service delivery are necessary for effective cost containment if the U.S. is to have an affordable health care delivery system. As a nation, we must decide what services we are willing to pay for and the most effective manner to deliver these services. The U.S. is now spending nearly 13% Of its GDP on health care (compared to 8% for most other developing nations) and by the year 2000 that number is expected to rise to 18%.

GM believes health care reforms are in order, if the U.S. is to meet the health care needs of its people and improve its competitiveness in global markets. If mature manufacturing companies are to succeed, it is essential that the actions we take truly contain costs and improve our competitive position. Towards this end, GM also supports efforts such as the incremental measures proposed by this Committee's Chairman, that move us in the direction of these goals and add to our understanding of this complex issue.

Thank you.

PREPARED STATEMENT OF KEVIN MOLEY

Mr. Chairman and Members of the Committee: I am pleased to be here this morning to talk about health care costs and how to contain them. This issue goes to the heart of any serious approach to health care reform. The President's Comprehensive Health Care Reform Program offers an effective response to this issue-one that is compatible with our American culture and expectations for a top quality health care system.

INTRODUCTION

We are all familiar with the numbers that document increasing health care costs. The unsettling implication of those numbers is that the rate at which health care costs are growing is unsustainable indefinetly—health care costs have been increasing at 2 to 3 times the rate of the rest of the economy. No segment of our economy is immune from the effects of this as we witness expenditures on health care consuming more and more of our resources each year.

- Workers face lower wages than they would if health costs were lower.
- Individuals face stiff premium increases and growing out-of-pocket costs.
- Federal and State governments find health care their biggest budgetary problem.
- The portion of our economy devoted to health care increasingly squeezes our Nation's resources and ability to support other important priorities-housing, education, infrastructure-priorities that are essential to sustain and improve our current standard of living.

The Secretary has said repeatedly that we spend enough on health care: "It seems that the $2,700 spent on average for each and every man, woman and child in this country *ought* to be enough. This is more than any other country in the world, yet despite this expenditure, more than 13 percent of Americans are without any health insurance at all." I agree with the Secretary. It is clear we need to spend our dollars more efficiently and wisely.

The President's Comprehensive Health Care Reform Program, announced last February, carefully builds an approach to health care reform that meets the twin challenges before us of expanding access and containing costs. Parts of this program are reflected in the bills we transmit this week to Congress and additional legislative language detailing the plan will be transmitted in the coming weeks.

A MARKET-BASED APPROACH

The President believes strongly-after considering the consequences of the alternatives—that cost containment can best be achieved through restructuring the incentives in the market-based system. A market-based system allows and promotes consumer choice-both choice of providers and delivery systems. It further allows flexibility in coverage and benefits; fosters innovation; and allows more decentralized and individually based decision making through multiple local payers, providers and consumers.

Any alternative that is premised on substantial government control of choice, price or other aspect of the health care system through a centralized, regulatory system will never control costs effectively nor be compatible with American values. In developing the framework for our program, the President chose to build on what's best in the existing system and reform what doesn't work. Rather than place crushing mandates and massive tax increases on businesses, we chose to strengthen and empower the consumer.

PRESIDENT'S PLAN CONTROLS COSTS

To contain costs, the President's program creates cost-reducing market-based incentives, removes barriers to efficiency within the system, and controls cost drivers. The President's cost containment provisions should each have a positive influence on costs. In addition, the President's program obtains greater leverage from the provisions because they are designed to interact in a way that heightens the incentives to control costs and thus achieve an even greater savings impact.

The proposed initiatives in the President's program to make insurance more affordable and accessible would result in millions of new consumers—individuals and small businesses—looking in the market place for, and expecting to purchase, affordable health care. This sets in motion the market forces for a cost-containing, competitive health care system.

- Consumers will be looking for value in the market place.
- Many providers and insurers will want to serve these new consumers.
- Insurers, because of the President's private insurance reforms, will no longer be competing on the basis of insuring only the healthy, and will be competing on the basis of cost-containment and quality.

As a result, we can expect that services provided and benefits offered will be responsive to the consumers preferences and needs.

What the President has proposed here will empower the consumer through choice and competition to influence the local market toward cost-containing action-rather than create new centralized bureaucracies that revert to price controls or global budgeting that blunt the local market power.

To add additional impetus to the incentives already underway, the President's Program would substantially increase consumer information. A "Blue Book," like that available to purchasers of automobiles—would compare costs and coverage options as well as quality information and would add further stimulus to large purchasers and individual consumers alike to make cost-effective choices.

The President would also remove the barriers to cost-effective choices involving coordinated care systems, well recognized for their high quality and high value. Coordinated care systems are one of the best ways to reduce fragmentation of services and excessive use of services and are a centerpiece of the President's program. State laws limiting coordinated care and mandating costly, non-essential services would be preempted. We will also develop the initiatives to increase the use of coordinated care systems by Medicare and Medicaid beneficiaries.

In tandem with these initiatives, the President's Program also launches reform initiatives that target cost-drivers which spur on the inflationary tendencies of our present system. I want to mention two in particular:

One is our present medical malpractice system which provides the perverse incentive for providers to order extra tests and procedures primarily for subsequent protection in the courtroom rather than for the patient's health. A comprehensive liability reform plan as proposed by the President will reduce the $20 billion annual cost of defensive medicine and malpractice litigation that burdens our health care system.

- The second is the administrative system which can be streamlined and simplified to reduce overhead costs for small business and eliminate costly inefficiencies. The Department is pursuing strategies to reduce administrative waste, including electronic information sharing, uniform data transmission standards, electronic cards, streamlining medical review and developing computerized patient record systems. In the next few years, we envision that all eligibility verification, billing claims adjudication and payment will be conducted electronically and clinical information will be computerized and exchanged through electronic networks. Private sector workgroups and Departmental initiatives are already taking the steps necessary to reach this goal. These information activities will be coordinated with the President's "Blue Book" initiative providing quality data for consumer choice.

The final cost-containment feature I want to mention today is a special one because it brings with it important benefits, and that is the powerful potential of better primary and preventive care. These activities give us the best of both worlds: they improve health and enhance quality of life and they also contain costs. There are things we can do for ourselves that vastly improve our quality of life, yet also save health care costs. The cost of inaction is high: Cigarette smoking alone accounts for one out of every six deaths, or 390,000 lives lost a year while reaching $65 billion in smoking related health care costs and lost productivity. Prevention of low birthweight babies through increased access to early, appropriate prenatal care and education is especially cost effective: For every low-weight birth avoided, the health system saves between $14,000 and $30,000 in newborn hospitalizations and long term health care costs. The Administration is aggressively pursing a number of beneficial initiatives including Healthy Start and expansion of the Women, Infants and Children program.

CONCLUSION

In conclusion, these actions will make bold inroads into containing costs by restraining the inflationary elements and inefficiencies in our current system. I believe the President's Comprehensive Health Care Reform Program just outlined offers an effective approach to cost containment in a fashion that would be acceptable and compatible with American expectations and would ensure that we do not undermine the high quality system we now have.

RESPONSE OF DEPUTY SECRETARY KEVIN MOLEY TO A QUESTION SUBMITTED BY SENATOR WELLSTONE

Question. You referred to the Administration's proposal to use the device of health insurance networks as the way to make health care more accessible and affordable. How do you explain the fact that COSE in Cleveland, the model for this proposal, opposes this element of the President's health care reform package, and the package overall, as ineffective?

Answer. First, the President's vision for health insurance networks (HINs) transcends any single existing model. There are elements of many insurance purchasing arrangements, both existing and remaining to be tried, that form the conceptual basis for what the President believes HINs could be and could accomplish. As put into practice, we would expect HINs to vary according to other aspects of the health financing and delivery systems in different areas, and we would expect them to be organic, evolving based on direct experience and the experience of other similar groups.

Second, as is true of any of the reform proposals, different views may emerge over details; however, COSE representatives have told us that they are in favor of the principles undergirding the President's proposals and the reform design, and are in favor of the HINs approach to small group insurance.

COST CONTAINMENT IN THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM

OVERVIEW

In the debate over health care reform, two basic approaches to cost containment have emerged. One approach would limit total national expenditures and try to set payment rates accordingly. The other approach would reform the underlying forces that have caused health care costs to rise.

In the absence of underlying reforms of the incentives driving up health costs, the payment cap approach is tantamount to a pressure cooker -- everything pushing costs up against a cap.

By contrast, the President's Comprehensive Health Reform Program addresses the incentives that contribute to rising expenditures, thereby improving the affordability of health care for individuals and businesses in addition to reducing overall expenditures. It is based on the same principle found in medicine -- where possible, address the causes, not simply symptoms, of the problem.

Causes of Rising Health Care Costs

Health costs are rising because the individual actors in the system have at best muted incentives to be concerned about costs, and face incentives such as the malpractice system which encourages more care rather less, even when it is not medically necessary. For those participants who do wrestle with costs, they face a series of barriers - explicit and implicit -- to dealing with the increases in the volume and intensity of services that are driving cost increases.

The President's Approach to Cost Containment

The President's plan seeks to reform the health care market primarily through the restoration of cost-conscious and cost-efficient decisionmaking, a fundamental aspect of an efficient market. All of the provisions in the plan -- incentives for cost-effective purchase of health insurance through tax credits, insurance market reforms, expanded use of coordinated care, information for purchasers, expanded focus on prevention, malpractice reforms, and automation of administrative activities -- would improve the ability of the actors in the health care system, including consumers, purchasers, insurers, and providers, to make rational, efficient decisions.

Interactions

The President's cost containment provisions, taken in isolation, should each have a positive influence on costs. An even greater change would occur, however, if all of these provisions were adopted. These reforms are interrelated

and would act synergistically – because decisions made by different actors in the health care system each affect one another.

Thus, in considering the impact on costs of, for example, the expanded use of coordinated care, one should factor in the effects of other reforms such as automated health information and insurance reforms that remove barriers to coordinated care. The whole would produce more savings than the sum of the pieces. The following highlights just a few of the interactions.

The Effectiveness of Coordinated Care

- The pre-emption of State anti-coordinated care laws and the clarification of anti-trust standards that restrict coordinated care organizations would facilitate efforts to expand the use of coordinated care in public programs and in the private sector. Reform of anti-trust standards would make such plans more effective in controlling costs.

- Coordinated care programs would be even more cost-efficient than they are now as a result of the automation of clinical recordkeeping and the dissemination of health outcomes measures. They would be able to form better provider networks, using comparative information about physicians and hospitals. Medical review would be more effective as a result of the computerization of patient data and use of expert systems.

- The recipients of tax credits in the President's plan would create a significant demand for lower-cost plans, and insurers and providers would compete to meet the demands of this new group of consumers by developing and offering more efficient health plans, such as coordinated care plans.

Information for Purchasers, Small Group Reforms, and Tax Credits.

- The small group reforms would expand the number of small businesses that offer health benefits through insurance market reforms and through HINS. These businesses would have a great need for the information on providers and plans that States would provide under the President's plan.

- In addition, more business interest in such data would encourage greater hospital participation and would provide impetus to improve data collection systems.

- The insurance reforms would also improve the ability of all employers to develop provider networks by pre-empting State laws. Employers could then use information on providers to develop more cost-effective networks.

- Having a new large group of cost-sensitive consumers would not generate savings if those consumers had to face the usual problems that exist in the small group insurance market. The President's Plan would dramatically reform the small group market, making possible the purchase of insurance by tax credit holders.

- The development and dissemination of information about insurers and providers to consumers would greatly improve tax credit holders' ability to shop around for the right health plan.

Documentation of Cost Containment Effects

Academic literature and real world examples provide evidence of the cost containment potential of the President's plan. The chapters that follow outline some of these examples and research, as well as describe how provisions interacts with others in the President's plan.

I. HEALTH INSURANCE MARKET REFORMS

SUMMARY:

- The President's plan would reform the private health insurance marketplace to enable it to function in a more efficient and equitable manner.

- The plan would stabilize the small group market with interim rating restrictions and risk sharing mechanisms. It would then test and phase in longer term approaches to risk sharing.

- Small group reforms in the plan would mean insurers would have to compete by managing health costs rather than by selecting good risks.

- Administrative reforms in other parts of the plan would be especially helpful to small firms now burdened by exceptionally high administrative loading in their health insurance premiums.

- The plan would provide incentives to encourage the formation of health insurance purchasing groups called Health Insurance Networks (HINs), so that small employers could benefit from economies of scale.

- The plan would pre-empt, for all health insurance, State mandates and anti-coordinated care restrictions, which studies have demonstrated add unnecessary costs.

I. HEALTH INSURANCE MARKET REFORMS

INSURANCE REFORMS

The President's plan would make health insurance more affordable through reforms of dysfunctional health insurance practices. By requiring insurers to adopt certain ways of doing business, consistently and fairly, the reforms would bring needed stability and predictability to both insurers and employers. Such stability would enable them to return to an approach of spreading health care costs broadly and to devote their creative energy to cooperatively managing risks and health care costs rather than competing to avoid them.

Insurers, if they offered coverage to any small employer, would be required to offer and renew the same plans to all small employers, to abide by reasonable rating limits, and to participate in risk-sharing mechanisms operated at the State level. These reforms would expand and stabilize coverage and reduce the rate of increase in premiums for small employers.

All employment-based health insurance, including that offered by employers that self-insured, would operate on a level playing field with regard to pre-existing condition exclusions. This would significantly reduce insurers' need for building costly contingency funding to protect against adverse selection into the administrative loading for premiums.

RISK SHARING

The President's plan recognizes that pre-empting State mandates and adopting premium rate restrictions alone would not be sufficient to restrain future cost increases. Rate limits, such as those proposed by the NAIC, insurers, and many Congressional bills, are important to stabilize the market and prepare it for the crucial second step -- pooling and adjusting for each insurer's share of risk and providing incentives to manage it.

Insurers that wished to participate in the market for small employers would be required to abide by interim premium rate restrictions and to participate in State-level reinsurance, allocation, or other risk sharing mechanisms. Insurers with more than their representative share of high risks would thus be protected against an unreasonable cost burden.

At the same time as the interim rating and risk sharing mechanisms were put in place, the President's plan would provide for development and phased-in implementation of a more stable, long-term small group risk sharing program,

similar to the approach advocated by GHAA and Kaiser Permanente before the NAIC and with the California State legislature. Insurers with a relatively low risk book of business would compensate those with higher risks. This would eliminate the incentive (and effort and costs) associated with risk selection in the current market.

Because the small employer market now produces relatively low premium rates for those small employers that are considered good risks, both the interim rating and risk sharing mechanisms and the later long-term risk sharing programs would be phased in. Thus, incentives for insurers to identify and avoid high risk individuals and the administrative costs of doing so would be reduced. In addition, equity and coverage among insurers, employers, and individuals would increase.

EMPLOYER POOLING

The President's plan would provide a mechanism for small firms to benefit from the advantages of large size by helping them form small employer pooling mechanisms known as Health Insurance Networks (HINs). The President's HIN approach would bring the benefits of pre-emption of State requirements and economies of scale to small employers.

Some of the cost advantages enjoyed by large employers derive from the privileges of self-insurance (pre-emption of State mandates, anti-coordinated care restrictions, and premium taxes). Others derive from economies of scale (market clout, expertise in negotiating with insurers and providers, common administration with reduced overhead costs and improved management of claims).

The benefits of pooling would be available to HINs that contract with private insurers to offer coverage to participating employers. Thus, a number of HINs would become attractive markets in which insurers would compete with affordably priced benefit packages complying with market reforms.

The President's reforms would reduce administrative costs and premiums, particularly for small employers who are burdened by exceptionally high administrative loading charges. According to the Congressional Research Service, firms of 19 or fewer employees with conventional health insurance pay administrative charges in their premiums totalling 30 to 40 percent, while conventionally insured firms of 500 or more pay a total of between 5.5 and 12 percent. Administrative reforms would help reduce the general and claims administration expense parts of the loading for firms of all sizes. In addition, as pooling increased and churning in the small group market decreased, the

commissions and risk and profit charges which account for much of the difference between small and large firm premiums, should also be reduced, lowering small firms' relative premium costs.

One inspiration for the President's HIN concept comes from the widely-praised Council of Small Enterprises (COSE) in Cleveland. COSE is a purchasing group organized in 1973 as a non-profit component of the Greater Cleveland Growth Association, Cleveland's Chamber of Commerce. By April 1991, about 8,000 small businesses were participating with 60,000 employees and 85,000 dependents covered. Employers now have 12 group health plans available through six carriers from which to choose, including HMOs and PPOs often unavailable to small firms. COSE uses its combined purchasing power to keep insurer administrative costs low. It offers premiums that are 40 to 50 percent lower than comparable plans that small employers could purchase on their own. Its total premium increases over a recent six-year period were more than 100 percent lower than comparable plans.

STATE MANDATES AND ANTI-COORDINATED CARE LAWS

As a whole, State laws that mandate benefits and inhibit coordinated care practices are a major barrier to affordable health insurance, particularly for small businesses that cannot self-insure. The President's plan would bring the economic advantages of pre-emption to small firms that are unable to bear the risk of self-insurance by pre-empting those State laws for all small firm insurers nationwide.

State Mandates

Requirements to cover certain specified types of services, populations or providers are a phenomenon that has added costs to insurance policies in many States. The National Center for Policy Analysis estimated that in 1970 there were only 30 mandated health insurance benefits in the U.S. August 1991 data compiled from a variety of sources by the Health Benefits Letter places the current number of State mandates at nearly 1000.

A number of organizations have tried to quantify the costs of mandates on employer health insurance.

- Jensen and Gabel, in a 1989 HIAA Research Bulletin, indicated that in 1985 and 1986 the numerous mandates enacted by the State of Maryland accounted for 21 percent of all incurred claims for Blue Cross of Maryland. Using another method for measuring costs, HIAA actuaries priced alternative insurance products in Maryland and concluded that

mandated benefits raised the price of individual coverage by about 12 percent and family coverage by about 17 percent.

- More recently in 1991, Blue Cross/Blue Shield of Massachusetts estimated that mandates in that State accounted for 17.6 percent of their claims payments, while Blue Cross/Blue Shield of Virginia estimated that State mandates accounted for 21.3 percent of their claims payments.

Some of these services might have been covered in the absence of a mandate, but the mandate removes the option for small employers because they cannot afford the risk of self-insurance.

- An econometric model by the National Center for Policy Analysis cited in their 1991 testimony, estimated that as many as 25.2 percent of the uninsured nationally (and as many as 60 percent in Connecticut, Maryland, and Minnesota; 41 percent in New York, and 30 percent in California, Maine, and New Jersey) lack health insurance due to State mandates.

- Jensen and Gabel came to similar conclusions in comparing information from two studies of individual company level data. They concluded that State mandates accounted for 20 percent of non-coverage in their 1985 sample and 43 percent in 1988.

  Jensen and Gabel indicated that continuation-of-coverage requirements accounted for a portion of these costs, due to increased administrative costs and significant adverse selection. However, when persons with pre-existing conditions are assured of inclusion in health insurance provided through a subsequent employer (as the President's plan would do) then the need, the prevalence, and the cost of continuation coverage should be significantly reduced.

States have begun -- unevenly -- to address the impact of mandates on small firm health insurance.

- According to the Blue Cross/Blue Shield Association, by July 1991, 19 States had enacted legislation requiring a financial impact statement before enacting any new proposed mandates.

- Blue Cross/Blue Shield also indicated that, as of October 1991, 22 States had enacted laws permitting insurers to offer basic benefit plans exempt from some or all State mandates.

- The Health Benefits Letter reports that a few States waive premium taxes

or provide state tax credits or premium subsidies for small employers.

- The National Association of Insurance Commissioners is tracking the progress of a number of States that have enacted part or all of NAIC model laws that waive mandates and restrict rating, issuance, renewal, pre-existing condition exclusions, and other practices of small firm insurers.

Anti-Coordinated Care Laws

State restrictions on commonly used coordinated care efforts also interfere with the design of affordable insurance products for individuals and small businesses.

- Data on State legislation compiled by the Health Insurance Association of America (HIAA) shows that the enactment of new anti-coordinated care laws appears to be increasing. In 1990, 11 States enacted 14 bills on this subject;, while in 1991 enactments increased to 20 States with 26 bills.

- Unpublished data from the Blue Cross/Blue Shield Association indicates that, as of 1991, a total of 32 States had enacted 47 laws restricting coordinated care activities.

- The Wyatt Company surveyed 17 health care organizations to estimate the costs associated with six common anti-coordinated care restrictions. In their 1991 report for HIAA, they reported that restrictions such as allowing any willing provider to join a network could add from 34 percent to 52 percent to administrative costs, plus adding from 8.8 percent to 14.2 percent to claims costs. Requiring local utilization review personnel to be licensed in the same State and denial review by physicians of the same specialty as the attending physician was estimated to add from 33 to 35 percent to administrative costs. While additional, more comprehensive analysis on these subjects would be helpful, these data give preliminary indications of the magnitude of the problem.

- Lewin/ICF, in an analysis of a number of proposed cost containment initiatives, indicated that if State barriers to selective contracting, utilization review, and other coordinated care practices were pre-empted, there would be an estimated ten percent increase in the number of workers in HMOs, and that HMOs would reduce health spending for these newly covered workers by about ten percent.

INTERACTIONS WITH OTHER PROVISIONS

Systemic Reforms

Small group reforms would be more effective in reducing health insurance costs for small employers when combined with other reforms that reduce health care costs generally. The President's plan includes a number of such reforms of the underlying system, including malpractice reform, encouraging coordinated care, personal responsibility and prevention, and reducing administrative and paperwork costs.

Information for Purchasers

The effectiveness of the insurance market reforms would be particularly enhanced by an expansion of information available to purchasers. The pre-emption of State anti-coordinated care laws would improve the ability of insurers to create and employers to use provider networks when information about providers' quality and costs is more readily available.

II. TAX CREDITS AND DEDUCTIONS

SUMMARY:

- In contrast to most consumers in the current market for health insurance, who have only muted incentives to consider costs in their purchases of health insurance, recipients of tax certificates would have a strong incentive to be prudent in their choice of a health plan.
- The existence of a more efficient market for health insurance and health care would place pressures on the larger market, thereby driving down overall health costs.
- The expanded coverage through tax credits and insurance reforms would lower the costs of care by reducing delays in seeking care and the use of more inappropriate treatment and would also act to reduce the amount of cost shifting among payers.

II. TAX CREDITS AND DEDUCTIONS

Tax credits are an efficient way of providing subsidies for health insurance because they do not exacerbate the inflationary effects of the tax treatment of employer-provided health benefits. In fact, the provision of tax credits to 95 million individuals would create a new, more efficient market for health insurance.

INEFFICIENCIES IN THE CURRENT MARKET FOR HEALTH INSURANCE

In contrast to most consumers in the current market for health insurance, who do not have an incentive to consider costs in their purchases of health insurance, recipients of tax certificates would have a strong incentive to be prudent in their health care purchases.

DEMAND FOR HEALTH INSURANCE AMONG TAX CREDIT HOLDERS

The market for health insurance among holders of the tax credit would be more efficient than the current market for health insurance. Tax credit recipients would be more likely than individuals who receive health benefits from an employer to be concerned about the cost of their health plans because their amount of subsidy would be fixed, and they would have to bear the full cost of any purchase above the credit amount.

The existence of a more efficient market for health insurance and health care would place pressures on the larger market, thereby driving down overall health costs.

- The 21 million consumers who would be more sensitive to costs would create a significant demand for lower-cost plans, and insurers and providers would compete to meet the demands of this new group of consumers by developing and offering more efficient health plans, such as coordinated care plans.

- The expansion of more efficient health plans would drive down overall costs. Studies have demonstrated that market penetration by HMOs drives down costs of other health plans in the same area. (See Chapter III on Coordinated Care.) Just as hospital reactions to DRGs had a "sentinel effect" that helped changed lengths of stay for non-Medicare patients as well as Medicare patients, so the cost-effective health insurance plans generated for individuals with only the tax credits to pay

for premiums would have a ripple effect throughout the health system.

- Other consumers would also be able to take advantage of the expansion of more efficient, less costly health plans, even though their incentive to do so would not be as great.

MORE APPROPRIATE CARE AND REDUCED COST SHIFTING

The expanded coverage through tax credits and insurance reforms would lower the costs of care by reducing delays in seeking care and the use of more inappropriate treatment settings such as emergency rooms. Expanded coverage would also act to reduce the need for providers to shift the costs of uncompensated care to other payers.

INTERACTIONS WITH OTHER PROVISIONS

Insurance Market Reforms

The insurance market reforms in the President's plan would enhance the ability of tax-credit recipients to purchase insurance. Thus, it would increase the effect that tax credit recipients would have on the cost of health plans.

Consumer Information

The addition of a large group of cost-conscious consumers to the market for health care would generate significant demand for price and quality information about both insurers and providers. The President's plan would facilitate the development of comparative information for these individuals to use in deciding how to spend their tax credit. Because these individuals would be particularly interested in obtaining maximum value for the amount of their credit, they would seek out the price and coverage information to choose among insurance plans, and they could eventually use hospital quality data to choose a hospital or to evaluate a coordinated care plan's provider network.y

Medicaid

Medicaid-covered individuals in States that reorganized their Medicaid and tax credit program under one plan would replace Medicaid's work disincentives with positive work incentives.

Any reform that increased the cost-effectiveness of the health care system would also enhance the ability of tax credit recipients to purchase health insurance.

Thus, the expansion of coordinated care, increased prevention, and malpractice and administrative reforms would also contribute to the effectiveness of the tax credit.

III. COORDINATED CARE

SUMMARY:

- Coordinated or managed care has tremendous potential - only partially realized to date - to achieve savings through a variety of financial mechanisms and a reduction in unnecessary and inappropriate care.

- Evidence is accumulating on savings achieved by various forms of coordinated care - with the most evidence and most potential from the "strongest" forms of coordinated care - the health maintenance organization (HMO). The most notable study has shown 28 percent savings from HMOs.

- While some argue coordinated care savings is a one-time reduction, evidence is beginning to reveal that in areas where coordinated care penetration is high, savings not only spill over into the fee-for-service sector, but also reduce the rate of growth in total health care costs.

- While early evidence for many of the still-evolving forms of coordinated care showed minimal or no savings, recent studies suggest that these plans are changing practices in many ways that produce significant savings. In addition, some of the early studies considered only one aspect of health care costs and ignored such features such as reductions in out-of-pocket expenses.

- Most studies find that quality of care and patient satisfaction in coordinated care plans is comparable or higher than in the fee-for-service sector.

- Many explicit (anti-coordinated care laws) and implicit barriers have impeded the ability of coordinated care plans to achieve savings. If these barriers are eliminated, as proposed by the President, coordinated care will be more effective at controlling costs in the future.

III. COORDINATED CARE

COSTS AND UTILIZATION IN COORDINATED CARE PLANS

Under the President's reform proposal, emphasis is placed on coordinated care as a means of improving the efficiency of the health care delivery system, expanding access to care, as well as ensuring quality of care. Coordinated care refers to a diverse and still evolving set of health care delivery network models that integrate financing and delivery of care and alter incentives for providers and insurers. Coordinated care plans employ a wide variety of mechanisms to achieve the goals of increased efficiency and better value for health care dollars spent. These include care coordination, selective contracting, provider payment incentives, utilization review, pre-admission certification, case management, increased use of primary care and preventive services in place of more costly alternatives. Coordinated care reduces the fragmentation and potential for duplication of services inherent in fee-for-service (FFS).

Although we believe that coordinated care clearly achieves savings, a number of factors have made it difficult to reach conclusive findings on the cost-effectiveness of coordinated care. These include:

- o the complexity and diversity of plans - group model, staff model, IPA, PPO, POS and mixed models.
- o the evolving nature of coordinated care delivery,
- o the lack of data on newer models, and
- o pricing practices of some coordinated care plans of establishing premiums as a function of FFS plan premiums (i.e. shadow pricing).

Some remain skeptical of the ability of coordinated care to achieve cost savings. A key argument often presented by critics is that the reason HMOs are able to reduce utilization relative to FFS is because of favorable selection (i.e. individuals who enroll in HMOs are healthier than those who choose the FFS system). Although favorable selection may contribute to the better performance of coordinated care plans, available evidence indicates that coordinated care plans are still effective in the absence, or after controlling for, selection bias.

A Rand study conducted by Manning et al. controlled for differences in health status by randomly assigning individuals to an HMO or FFS. The study then compared service use and found that hospital admissions and days for the HMO group were 36 percent lower than admissions and days for the FFS group. In

addition, health expenditures per person were approximately 28 percent lower in the HMO group than the FFS group.

As part of a very recent medical outcomes study, Greenfield et al. examined the variations in health care utilization among systems of care for a cross-section of 20,000 patients of physicians in various medical practices and settings. Although the study found that variation in patient mix (i.e. health status, disease severity and sociodemographic status) was a major determinant of the variation in resource utilization, significant differences between FFS and HMO utilization still existed after controlling for patient mix. Specifically, Greenfield et al. found that FFS patients had 41 percent more hospitalizations and 12 percent more medications prescribed than individuals in HMOs, while HMO patients had 8 percent more physician visits than FFS patients.

Utilization and Costs in HMOs: Other Evidence

Siu et al. examined medical records from the Rand Health Insurance Experiment to compare rates of discretionary (i.e. potentially avoidable) and non-discretionary surgery between families randomly assigned to an HMO or a FFS plan. They found that HMOs had lower discretionary surgical and medical admissions rates than FFS:

- For discretionary surgical admissions, the HMO rate was 7 per 1000 person-years, compared to the FFS rate of 22 per 1000 person-years.

- The rate of discretionary medical admissions HMOs was 14 per 1000 person-years, while the FFS rate was 30 per 1000 person-years.

In contrast, the rate of non-discretionary surgical admissions for the HMO and FFS groups were not significantly different (18 per 1000 person-years and 20 per 1000 person-years, respectively). Thus, the researchers concluded that the HMO reductions in hospitalization rates are not across the board, but the result of reducing discretionary surgery.

According to the results of the Group Health Association of America (GHAA) Annual HMO Industry Survey 1991, average hospital days per 1000 people for HMOs was 394 days in 1990, 45 percent lower than hospital days per 1000 for the nation (710 days). In addition, GHAA found that average length of stay was 34 percent lower than the national average, respectively.

Another report by GHAA compared inpatient surgery rates reported by HMOs in 1989 and the 1988 National Hospital Discharge Survey for five procedures that have shown wide variability nationwide (hysterectomy, prostatectomy, coronary artery bypass, cardiac catheterization and cholecystectomy). GHAA found that

surgery rates were lower among HMO patients than the national rate, while the rate of a procedure that is not highly variable (inguinal hernia repair) differed little from national experience. The rates for the five procedures ranged from approximately 10 to 70 percent of the national rates. The GHAA survey data suggests that expansion of HMO enrollment would have a significant effect on overall rates of unnecessary surgery.

A study based on an earlier survey of 337 HMOs by Hillman et al. indicated that physician capitation, salary-based payment, and putting physicians at financial risk for physician and hospital referrals enhanced the ability of plans to control utilization. Specifically, study results showed that:

- salary-based payment was associated with a 13.1 percent reduction in hospital days;
- group-model structure was associated with 9.6 percent fewer hospital days; and
- putting physicians at risk for referrals was associated with 10.5 percent fewer visits per enrollee.

The Foster Higgins Health Benefits Survey of 1990 collected information on employer-sponsored health benefits plans and found that, although the average cost per employee for HMO increased by 15.7 percent in 1990, per employee cost remained 17 percent lower than traditional medical indemnity plan coverage. Savings for HMOs were expected to grow to 21 percent in 1991.

Independent Practice Arrangements (IPAs) are prepaid health plans that contract directly with individual and groups of physicians in independent practice to provide health services. Early evidence indicated that IPAs had limited success in controlling utilization and cost.

In a recent study of 41 HMOs, however, Nelson found that in contrast to the utilization control incentives employed by early IPAs, the IPAs in the study were just as likely to capitate their physicians as group model plans. Based on aggregate reported plan data, the IPAs had lower utilization rates than staff model plans..

Bradbury et al. examined 12 surgical procedures performed in 10 hospitals and compared the experience of IPA patients to patients belonging to commercial plans and Blue Cross Blue Shield. The authors found that IPA membership was associated with lower total charges (6 percent lower), lower ancillary charges (4.3 percent lower), and shorter lengths of stay (10 percent shorter). While variation existed among the different IPAs and among hospitals, the findings

consistently showed greater efficiency in the delivery of surgical procedures for the IPA members than for FFS members.

Preferred Provider Organizations

Preferred Provider Organizations (PPOs) are health care plans in which payers, usually employers, contract with selected providers under defined financial arrangements that encourage efficiency and cost-containment. These arrangements incorporate mechanisms employed by HMOs such as price discounts, utilization control, risk-sharing through capitation, and incentives for enrollees to use in-plan providers, while allowing more flexibility in the choice of providers. Available data on the performance of PPOs demonstrates that PPOs can be effective in controlling utilization and costs.

Data from the American Association of Preferred Provider Organizations on the 20 PPOs that have been fully accredited under the American Accreditation Program for 1990 and 1991 indicate that these organizations have achieved hospital utilization rates comparable to those achieved by HMOs (305 average inpatient days per 1,000 for fully accredited PPOs, 394 for HMOs (GHAA), 710 for the nation (GHAA)).

The 1990 Foster Higgins Health Care Benefits Survey showed that per employee medical plan costs for employers in PPOs were 8 percent lower than traditional indemnity plan costs in 1990. For capitated PPO arrangements, per employee costs were 16 percent lower than the costs for indemnity PPO plans. In addition, two-thirds of employers with PPOs responded that PPOs are effective in controlling their costs.

Point of Service Plans

In a point-of-service (POS) plan, an employee chooses a primary care physician to serve as a gatekeeper to a network of specialists and hospitals. By using the gatekeeper and network of providers, the employee receives HMO-like benefits while retaining some freedom of choice allowed by an indemnity plan. Because most POS plans are relatively new to the health care market, little data is available on the performance of these plans. However, an analysis of claims experience of POS plans with primary care gatekeepers performed by the Wyatt Corporation found savings associated with the gatekeeper function of 4.2 percent to 13.5 percent of total claims.

TRENDS IN SAVINGS FROM COORDINATED CARE

Critics of coordinated care have expressed skepticism of its ability to generate

on-going savings. However, according to GHAA data, HMO premium increases in recent years have consistently been below the level of growth in premiums for indemnity insurance. This is true despite the fact that indemnity plans in the last few years have been increasing copayments, which would normally reduce the size of the premium increase, while copayments faced by HMO enrollees have generally remained constant.

"SPILL-OVER" SAVINGS FROM COORDINATED CARE

Recent evidence suggests that higher levels of HMO market penetration are associated with lower FFS costs in the market area.

Robinson compared the impact of HMO market penetration on hospital cost inflation in California hospitals between 1983 and 1988. The study revealed the following:

- Hospitals that operated in high penetration markets experienced an average rate of growth in costs per admission 9.4 percent lower than markets with low HMO penetration between 1982 and 1988.

- In 1988, those hospitals with estimated savings greater than 15 percent were in markets with high HMO penetration.
- Seventy-five percent of the hospitals in the study had an estimated HMO-induced cost savings between 1 percent and 12 percent.

- HMO coverage grew from an average of 8.3 percent of all admissions in local California hospital markets in 1983 to 17 percent of all admissions in 1988. Robinson estimated that the decrease in hospital admissions and utilization associated with this increase in HMO market penetration has resulted in a cost savings of $1.04 billion in 1988 for the hospitals in this study.

A recent study conducted by the Florida Health Care Cost Containment Board of 1990 data from 210 hospitals in Florida found that the presence of HMO or PPO patients tends to lower hospital costs and HMO revenues. The Board estimated that if the percentage of HMO/PPO patients of an average hospital were to double, the result would be a decrease in net revenue per adjusted admission by 4.22 percent.

Welch revealed that for every 10 percentage point increase in HMO market share, Medicare expenditures decline by 1.2 percent in the short run and by as much as 3.9 percent in the long run. We remain interested in more rigorous studies in this area.

A study conducted by Thompson compared hospitals in areas of high and low HMO market penetration between 1986 and 1990. After adjusting for case mix and wage levels, the findings reveal:

- High HMO market penetration (i.e. markets with 21 to 32 percent HMO enrollment) was associated with slower rates of growth in the median adjusted expense per hospital admission. The expense per adjusted admission in low penetration areas (i.e. markets with 10 to 12 percent HMO enrollment) increased at a compounded annual rate of 7.83 percent, double the rate in high HMO enrollment areas (4.46 percent).

- The average annual rate of decline in LOS was higher for hospitals in high HMO enrollment areas (3.83 percent) than hospitals in low HMO enrollment areas (2.56 percent).

- Hospital revenues per admissions in areas of low enrollment grew at an average annual rate relatively higher than in high enrollment areas (5.46 percent versus 3.88 percent, respectively). Furthermore, hospitals in low HMO penetration areas were more profitable than high penetration areas (total profit margins were 3.28 percent and 2.17 percent, respectively).

QUALITY AND PATIENT SATISFACTION IN COORDINATED CARE PLANS

Available research indicates that the quality of care in coordinated care plans is comparable, and in some cases, better than FFS. Additionally, numerous studies have shown that enrollees are satisfied with the coverage and quality of care they receive in HMOs. (See Appendix)

Quality of Care in Medicare Coordinated Care Plans

The National Medicare Competition Evaluation (NMCE) examined the cost of care and quality of care under Medicare risk-based HMO contracts. A series of studies based on the NMCE data provides convincing evidence that the quality of care in Medicare HMOs is at least equivalent to the care delivered to similar patients in the FFS sector. In fact, Medicare HMO enrollees were more likely than FFS beneficiaries to have routine and preventive services and follow-up visits performed.

In addition to high quality medical care, coordinated care plans provide other innovative services that aim to improve quality of care for Medicare beneficiaries. For example:

- A number of HMOs have made special arrangements for delivering

primary care to the elderly by designating centers that serve the elderly exclusively.

- Other plans have taken steps to promote coordination of services, creating specialized teams dealing with geriatric issues.

- Many plans require that all new staff attend a geriatric orientation program.

- Several plans are addressing the appropriateness of drug use, encouraging the elderly to assemble medications and meet with pharmacists.

Quality of Care in Other Coordinated Care Plans

Studies on the quality of ambulatory and preventive services in coordinated care plans have shown that the quality of care received by HMO patients was equal to or better than the care received by FFS patients in the studies. In addition, one study found that higher quality standards were observed in preventive services furnished to HMO patients. Another study conducted by RAND that compared medical expenditures and health outcomes of children randomly assigned to FFS and HMO plans found that: 1) there were no differences in imputed total expenditures between the two groups and 2) children in the FFS group had 50 percent fewer medical contacts and received 40 percent fewer preventive services than children assigned to HMO plans.

INTERACTIONS WITH OTHER PROVISIONS

All of the above achievements of coordinated care have occurred in spite of numerous barriers to coordinated care. Thus, expectations based on the current performance of coordinated care plans are not too high. Without impediments, the effects of coordinated care on costs would be even greater.

Pre-emption of Anti-coordinated care laws

Under the President's plan, federal legislation would pre-empt state laws and regulations that attempt to restrict the flexibility of coordinated care plans.

- According to the Health Insurance Association of America (HIAA), 195 pieces of legislation have been introduced or enacted by states during the 1991 sessions that could restrict the growth of coordinated care. These provisions are aimed at limiting the ability of coordinated care plans to control costs and reduce inappropriate or unnecessary services.

- In 1991 the Wyatt Company studied and estimated the costs associated with six state legislative provisions that would mandate state control of the practices employed by coordinated care plans. For example, the report revealed that mandating that "any willing provider" be permitted to join a managed care network results in an increase in administrative costs due to the progressively larger network of participation. It also found that prohibiting "gatekeeper" physicians in PPOs could result in a 6.83 percent loss of claims savings. In conclusion, the report found that all six mandates result in substantial increases in administrative costs, as well as some reductions in cost savings.

Administrative Reforms

The President's plan emphasizes the need to reduce the administrative costs of health care. Because coordinated care combines the delivery and financing of health care, HMOs and other coordinated care plans are not claims driven, and thus generally experience lower administrative costs than their indemnity counterparts.

According to the Group Health Association of America, HMO plans in 1989 spent 9.4 percent of the mean total expense per enrollee per month on administrative costs, while 12.2 percent of total personal health spending nationally was spent administrative costs. In 1990, several of the larger plans reported administrative costs between 2.5 and 5.1 percent. Considerable variation exists among methods for calculating administrative costs and definitions of administrative costs for a given plan.

Information for Purchasers

A critical element of the President's plan is to require states to provide comparative information to individuals and employers on the quality and costs of health care plans and providers. This proposal would dramatically increase the amount of available information about the quality of providers and would therefore greatly enhance the ability of employers and coordinated care plans to develop provider networks. By providing more information about costs, benefits, and quality of health plans to individuals, it would also facilitate the consideration of coordinated care plans.

Tax Credits

Tax credit recipients would be more cost-sensitive consumers than those who receive health benefits from an employer, because they would experience the

full marginal costs of their health insurance purchases. Thus, this large group of new consumers would be more likely to seek out cost-efficient health plans. The market for coordinated care plans would expand.

Anti-trust provisions

Clarifications in antitrust policy would play an important role in fostering increased use of pooling arrangements such as those used in PPOs and HMOs.

- The President's plan would clarify antitrust standards so as not to discourage physicians from banding together in these type of arrangements for fear of breaching antitrust laws. The increased guidance that would be forthcoming would assist providers in fashioning arrangements that were consistent with the antitrust laws.

- At the same time, the President's plan calls for increased antitrust enforcement against those in the health care industry who boycott such provider organizations.

IV. COMPARATIVE VALUE INFORMATION FOR HEALTH PURCHASING

SUMMARY:

- Unlike consumers in many other markets, purchasers of health care often do not base their decisions on comparative information. Both individuals and large-scale purchasers of health care need more objective information about health plans and providers.

- A considerable amount of research demonstrates that individual consumers are sensitive to health care costs and that they are capable of incorporating information about providers and health plans in their decisions.

- The technology for measuring quality of care is rapidly developing and is in use by many hospitals, employers, and insurers.

- Pennsylvania, Iowa, and Colorado have passed legislation requiring the measurement of hospital treatment outcomes. Employers in Pennsylvania are using the outcomes data to select among providers.

- Many employers in States that do not mandate outcomes measurement have overcome numerous obstacles to collect hospital outcomes data.

- Improvements in this area would improve the cost containment ability of nearly all other cost containment proposals in the President's plan.

IV. COMPARATIVE VALUE INFORMATION FOR HEALTH PURCHASING

The lack of information in health care transactions is a commonly cited source of market failure in markets for health insurance and health services. Recent developments in quality measurement, medical recordkeeping, however, make it possible to remedy imbalances of information among health insurers, large purchasers of health insurance, individual consumers, and providers.

The reforms in the President's plan would strengthen the market forces in health care and promote aggressive competition among insurers and among providers. Thus, they would increase the importance of purchasers' ability to make effective decisions about health care and health insurance.

INFORMATION NEEDS IN THE HEALTH CARE MARKET

In most markets, buyers take into account the price and quality of goods in their purchasing decisions. Buyers of health care -- both individuals and large-scale purchasers, however, tend not to have full information on what they are getting for their money. Individuals often rely on referrals from their family physician, family members or friends in choosing physicians and hospitals. When choosing among insurance plans, they do not always have easily-comparable data on the differences between plans. Insured individuals have not demanded more information because they have been wholly or partially insulated from the costs of their health care decisions.

Many employers do not discriminate among hospitals, and those who do contract with hospitals tend to make selections based on location or on the availability of discounts. Recently, because of rising health costs, more employers have begun to seek information on the value of their health care purchases. They have begun to realize what purchasers in almost every other market besides the health care market have known -- that simply choosing the lowest priced goods does not control costs. Hospitals have also begun to realize the importance of measuring quality, both to improve the cost-effectiveness of their services and to meet the demands of employers and insurers.

The types of information that are useful to different players in the health care system are characterized in the table below.

TYPE OF INFORMATION

TYPE OF CONSUMER	PROVIDER INFORMATION	INSURANCE INFORMATION
INDIVIDUALS		
LARGE PURCHASERS		

Large purchasers of health care, such as employers, need comparative information about providers to choose among health plans and to develop more efficient provider contracts and provider networks.

Individual consumers need comparative information on providers to choose among hospitals and physicians and to help them select coordinated care plans that restrict access to a network of providers.

Purchasers and individual consumers also need comparative information on the benefits and prices of different insurance plans and coordinated care plans.

USE OF INFORMATION BY INDIVIDUAL CONSUMERS

Opponents of competitive approaches to health care reform argue that patients do not behave as rational consumers in response to rising health care costs and that they are not capable of making informed choices about their health plan or provider. Much evidence indicates otherwise.

Consumer cost-sensitivity.

Several studies have found that individuals are responsive to price when selecting health insurance or a physician.

The RAND Health Insurance Experiment found cost sensitivity among patients dependent upon out-of-pocket expenses. Spending rates and number of medical contacts varied between plans with no cost-sharing, intermediate cost-sharing and 95 percent coinsurance.

Long, et.al., examined economic factors influencing consumers' health care decisions by evaluating disenrollment in health maintenance organizations. The

authors found correlation between premium increases and disenrollment, regardless of other factors.
Similarly, LaTour, et.al., found some price sensitivity among Medicare beneficiaries who were asked to choose between insurance plans under a hypothetical voucher system.

Hibbard and Weeks (1987) also discovered price sensitivity among health care consumers. The provision of physician fee information particularly increased knowledge and the saliency of cost issues for younger, employed consumers. Additionally, three subgroups -- those with at least one physician visit during the study period, those with greater exposure to the health costs, and those who perceive health care costs as burdensome -- were more sensitive to fee information.

Consumer Knowledge and the Need for Information

Statements that consumers do not make rational economic choices is not surprising, since good comparative cost and quality information on health plans and health care providers is not currently available. Recent research indicates a need for information on the part of individual consumers and a dearth of available information.

Latour, et. al. discovered that many Medicare beneficiaries would have trouble choosing between health plans under a voucher system because they lack necessary information on competing plans. In addition, beneficiaries have difficulty comprehending health insurance, particularly deductibles, copayments and coverage exclusions. LaTour called for consumer education efforts to remedy this problem.

Mechanic (1989) argues that consumer choice is constrained by consumer ability to collect comparative information and match personal preferences with plan characteristics. He identifies the lack of information on plan performance and quality of care as particular constraints on rational choice. This informational vacuum is so pervasive, he argues, that many consumers rely solely on experiential information, particularly their relationship with a physician and premium costs.

One survey of consumers found that the most common reason for having a preference for a particular hospital care was "good medical care." (Inguanzo, 1985.) Other studies have demonstrated, however, that consumers are not able to evaluate what constitutes "good medical care" themselves (OTA, Cleary and McNeil, 1988), suggesting a need for information on quality of care for hospitals.

Newhouse, et.al., found that consumers have little sophistication about issues

salient to choosing a physician, such as board certification, staff priveleges, and licensing practices. Consumers are more knowledgeable, according to this research, about care-related issues, including treatment recommendations, second opinions and unnecessary care.

Individual consumer decisionmaking

When information is available, consumers use it to increase their knowledge, and different decisions can result.

Choice of provider. Hibbard and Weeks (1985) found that consumers who sought information on physician fees would use fee information when choosing a provider.

A study by Christenson and Inguanzo (1989) found that patients have become more involved in choosing their hospitals and physicians, relying less on the recommendations of one physician.

A 1990 study of choices of provider (Modern Healthcare, 1990) and a study by Cousins (1985) found that patients may not be as loyal to a single provider as they used to be.

Choice of health plan. Davidson, et. al., found that consumer health insurance knowledge influenced Medicare beneficiaries supplemental insurance decisions; beneficiaries with similar health status chose different coverages depending on their knowledge level.

Mechanic (1989) argues that consumers will make rational choices about health plans and benefit packages when they have access to good comparative cost information. He predicts that performance data will further enhance consumers' ability to match their preferences across competing plans.

Federal employees are able to make choices among a large number of health plans in the Federal Employee Health Benefits Program. The program offers a large selection of coordinated care plans and indemnity plans. Employees receive extensive tables that facilitate comparison of the plans according to a number of factors, including, but not limited to cost. In addition, they utilize an independent annual publication that compares all of the plans.

In 1990, the Health Care Financing Administration was authorized to make grants to States for health insurance advisory service programs for Medicare beneficiaries. States will be counselling Medicare beneficiaries about Medicare, Medicaid, Medicare supplemental policies, long term care insurance, coordinated care plans, and other health insurance benefits.

THE DEVELOPMENT OF COMPARATIVE INFORMATION ON PROVIDERS

The technology for measuring quality of care already exists and is in use today. Providers have been using these systems to improve quality of care and for internal quality assurance. In addition, some States have been using these systems to make provider outcomes data more widely available.

Systems

The most sophisticated systems abstract data from directly from patients' medical records, measuring the severity of a patient's condition upon admission, during treatment, and upon discharge. Other systems utilize billing data only.

MedisGroups II abstracts data directly from patient medical record to develop severity-adjusted measures of outcomes. It reports the actual morbidity, mortality, and length of stay for procedures and compares them to expected figures based on other hospitals' data. The MedisGroups III database contains data from over 500 hospitals nationwide. Three States, Pennsylvania, Colorado, Iowa, have mandated the measurement of hospital outcomes and are using the MedisGroups III system.

Apache III (Acute Physiology and Chronic Health Evaluation) develops severity-adjusted health outcome measures for intensive care using billing and medical record data. It reports the outcome of care, length of stay, and nursing resources use, and it monitors appropriateness of admission. The system is designed to be used by physicians during treatment of patients.

Other systems. CSI (Computerized Severity Index) uses information from the patient record and reports on patient severity, length of stay, cost of care, and expected mortality. It can be used for individual physicians profiles. EQCEL (Evaluation of Quality, Costs and Effectiveness) reports on outcomes, physician practice patterns, and resource use using billing data and medical record data. AIM (Acuity Index Method) uses billing data to measure severity, length of stay, mortality, and charges.

Uniform Clinical Data Set (UCDS). The Health Care Financing Administration is beginning to collect medical record data in the Medicare program through UCDS. The system will be able to monitor appropriateness of utilization and analyze patterns of care by abstracting data directly from the patient record.

States Developing Comparative Information on Providers:

Three states have passed legislation requiring hospitals to submit medical

record data for the purpose of comparisons of clinical outcomes.

Pennsylvania passed legislation to form the **Health Care Cost Containment Council** and to begin gathering hospital data for the comparison of health outcomes in 1986. The Council has published reports comparing outcomes in 1989 and 1990, and it plans to publish a report on 1991 in the fall of 1992. It is preparing to begin measuring health outcomes of individual physicians for coronary artery bypass surgery.

Iowa has been collecting data from hospitals for comparison of medical outcomes since 1983. The State contracts with the **Health Policy Corporation of Iowa** (HPCI) to produce the report that compare health outcomes at 28 hospitals that have 100 or more beds. The HPCI contracts with the company MediQual, which performs the analysis of the hospital data. The HPCI just released its first report on April 17, 1992.

Many large employers in Des Moines will be using the data for competitive contracting of hospitals based on outcomes for cardiac care, obstetrics, and mental health and substance abuse treatment.

In the fall of 1991, the HPCI published the **Iowa Purchasers Guide to New Health Care Partnerships, Contracts and Accountabilities**, which encourages businesses and providers to enter into contracts for health care that are based on information about providers' quality and costs of care. Under such arrangements, providers would agree to participate in efforts to measure quality of care and health outcomes. The group of employers in Des Moines is testing the recommendations of the guide.

Colorado is still implementing a system for gathering data from hospitals for outcomes measurement. It expects to release its first report in July of 1992.

Several other States, including Ohio, Virginia, California, and Illinois are considering the possibility of measuring health outcomes in hospitals.

USE OF INFORMATION BY LARGE-SCALE PURCHASERS

Employers have traditionally contracted with hospitals or chosen among coordinated care plans based on location, convenience, and price information. In response to rising health care costs, more and more employers are now seeking to inform their choices with data on the quality of providers.

In the three States that have mandated the measurement of hospital treatment outcomes, businesses can readily obtain this information from the State. The

following are some examples from Pennsylvania.

- Hershey Foods has used data from the Pennsylvania Health Care Cost Containment Council on 22 area hospitals to develop a network of 10 preferred providers for 6500 of its employees. According to a recent survey, 8 to 10 Pennsylvania companies are on the verge of using the data in the same way that Hershey Foods has. (Wardrop, 1992.)

- Alcoa contracted with the Alpha Hospital Network in 1989 to coordinate care for its Pittsburgh employees based on outcomes measurements. Alcoa reports savings of approximately $400,000 in the first year and expects double the savings in the second year because enrollment in the network has doubled (Taulbee, 1991). Alcoa's costs for its Pittsburgh employees increased 10 percent in 1990, as compared to 16 percent for the rest if Alcoa.

- "Buy-right Councils". To combat high health care costs Business Roundtable of Pennsylvania started buy-right councils in 1986 to develop employer-provider contracts based on quality of care. Four of the five councils continue to exist in Erie, Pittsburgh, Lehigh Valley, and the Harrisburg-York-Hershey area.

In other States, many businesses have taken upon themselves the burden of obtaining data from hospitals in spite of a series of barriers they must often face. Business coalitions have demonstrated their interest in outcomes measurement.

- Cleveland Health Quality Choice (CHQC) will provide clinical outcomes and patient satisfaction data on hospitals to a coalition of health care purchasers in the Cleveland area. It will be releasing its first set of information on patient satisfaction, risk-adjusted outcomes of care among intensive care patients, and risk-adjusted outcomes of care among non-intensive care patients soon. In the future, it will be measuring quality among ambulatory care providers and coordinated care organizations.

  CHQC includes the fifty largest corporations in Cleveland and 8000 small businesses -- a total of 350,000 employees. In 1991, they invested about $600,000 for the program, and area hospitals contributed $2.6 million. CHQC has the support and participation of area hospitals.

- Central Florida Health Care Coalition, a large coalition of Florida employers, began in December 1990 to analyze admission rates and charges of area hospitals. It plans to measure risk-adjusted outcomes of

hospitals and to survey employers on employee satisfaction.

- The St. Louis Area Business Health Coalition collects price data from hospitals and surgical centers and disseminates this information to its members. It encourages its members to use the comparative price information in their purchasing decisions. It also encourages members to share the information with their employees. The coalition is developing a standardized pricing system for area providers.

- Alcoa. Based on its experiences in Pennsylvania, Alcoa is moving aggressively in its other locations to measure outcomes. (Wardrop, 1992. Taulbee, 1991)

INTERACTIONS WITH OTHER PROVISIONS

Administrative reforms

The automation of claims processing would greatly facilitate the development of pricing and health outcomes data. Abstraction of medical record data into a computerized system and especially the computerization of patient records would dramatically accelerate the process for producing outcomes measures for different hospitals and would reduce its costs.

Small Group Reforms

Small group reforms -- including Health Insurance Networks (HINs), risk pooling, and the elimination of underwriting -- would make insurance more affordable to small employers. As these employers entered the market for health insurance, they would particularly benefit from comparative value information. Employers would be able to decide whether joining a HIN or negotiating with local insurers would be most advantageous. They would use comparative information to choose an insurer or coordinated network and to develop insurance packages for their members.

Coordinated Care

The President's proposal contains provisions to greatly expand the use of coordinated care in public programs and to encourage its use in the private sector. The development of comparative information would make coordinated care plans even more effective at controlling costs because coordinated care plans would use comparative data on hospital quality to develop more efficient provider networks.

V. PERSONAL RESPONSIBILITY AND PREVENTION

SUMMARY:

- The delivery of preventive health services reduces unnecessary disease and decreases overall health expenditures.
- Studies clearly show that many preventive services such as timely pre-natal care and childhood immunizations are cost-effective.
- Counseling has been shown to be effective in encouraging life-style changes regarding tobacco use and nutritional status to reduce health care costs related to cancer and heart disease.

V. PERSONAL RESPONSIBILITY AND PREVENTION

COST-EFFECTIVENESS OF PREVENTIVE SERVICES

The President's proposals to improve preventive care services and to increase personal responsibility for health status are efforts to avoid both unnecessary disease and unnecessary costs to the health system. Preventive services have payoffs in improved health, lower medical costs, or both. Disease avoidance can mean significant cost avoidance and those areas of health care shown to be cost-effective should be aggressively pursued.

Low birthweight increases both the risk of infant mortality and the risk of illness. The prevention of low birthweight, through increased access to early, appropriate pre-natal care and education, has been shown to be one of the most cost-effective preventive health services.

> In a 1985 study, the Institute of Medicine found that every dollar spent on prenatal care targeted to high-risk women could yield $3.38 of savings in the total cost of caring for low birthweight infants. (Institute of Medicine, 1985)
>
> A later study found that for every low-weight birth avoided by earlier or increased prenatal care, the health system saves between $14,000 and $30,000 in newborn hospitalizations and long-term health care costs. (Office of Technology Assessment, 1988)
>
> Similarly, the Michigan Department of Public Health estimates that $6.12 in neonatal intensive care costs could be saved for every dollar spent on prenatal care. (Zickiln, 1992)

Employer incentives are also effective in encouraging the use of cost-effective, prenatal care. In a joint program between the March of Dimes and the self-insured First National Bank of Chicago, prenatal care is offered on-site and during work hours to employees. Women in the program who attended prenatal classes averaged $6,581 in costs per delivery, while those who did not attend averaged $9,815.

Multiple studies have shown that childhood immunizations yield considerable savings by avoidance of disease and its complications.

An estimated $5.1 billion in direct and indirect costs were saved during the first 20 years of the licensure of the Measles vaccination. (Bloch, et. al., 1985)

Another study found that over a six year period, a pertussis vaccine program saved $44 million in direct medical costs for a cohort of 1 million children. The savings-to-cost ratio was found to be over 11 to 1. (Hinman and Koplan, 1984)

EFFECTS OF COUNSELING ON LIFE-STYLE MODIFICATION

The 1989 Report of the U.S. Preventive Services Task Force reviews sound clinical reasons for counseling for improving life-styles and behavior. The Report cites numerous studies of effective counseling efforts to prevent tobacco use and to improve nutrition as well as many other preventive health efforts.

In 1985, smoking related health care costs and lost productivity reached $65 billion. (Office of Technology Assessment, 1985)

Smoking cessation is important to reduce both the numbers of low-weight births and the prevalence of disease such as cancers and vascular diseases in adults. About 18 percent of all cases of low birthweight babies are a result of mothers who smoke.

One study found that, compared with the costs of caring for low birthweight infants in a neonatal intensive care unit, smoking cessation programs would save $3.31 in health care costs per $1 spent on the programs. (Marks, et.al., 1990)

Over 90 percent of deaths from cancers of the lung, trachea, and bronchus are due to smoking. (Centers for Disease Control, 1987) Numerous studies have shown that counseling is effective in changing the behavior of people who smoke. (Russell, et.al., 1979, and Wilson, D., et.al., 1985)

As economic incentives, many insurers are also adjusting the costs of premiums for life, health and home owners' insurance related to smoking behavior.

Nutrition counseling and education has been shown to be effective in changing diets such as reducing fat and sodium, and increasing fiber and calcium. Because poor diets often play a significant role in causing diseases such as stroke and coronary artery disease, counseling for diet modification is an important way to reduce the costs of treating avoidable disease.

Glanz cited several studies that showed that counseling programs could effect dietary changes. (Glanz, 1985)

According to another study, more than half of the decline in deaths from

ischemic heart disease between 1968 and 1976 was related to changes in lifestyle such as reductions in cholesterol in the diet and cessation of smoking. (Goldman and Cook, 1984)

Employer wellness programs have also been shown to reduce health care costs.

The city of Birmingham, Alabama created a program for its employees that included health risk assessments, counseling for smoking cessation, weight loss, physical fitness programs and other wellness efforts, as well as an overhaul of its health care coverage to include a managed care delivery option. The program successfully contained costs such that the average cost of health benefits per employee rose only $28 between 1985 and 1990, from $2,047 to $2075. If costs per employee grew at the same rate as the medical care services CPI between 1985-1990, the costs per employee would have dropped by approximately $960.

INTERACTIONS WITH OTHER PROVISIONS

Market Reforms

Improved access to health services, as a result of tax incentives and market reforms for small employers, will allow more people to take advantage of cost-saving preventive services such as prenatal care and childhood immunizations. The savings attributable to effective use of proventive care services would directly offset some of the costs associated with providing the tax credits.

In addition, improved health status, as well as improved outcomes associated with access to care and early intervention will create less demand for expensive, reparative health care services in the system as a whole.

Coordinated Care

Coordinated care programs have become leaders in the U.S. health system in encouraging and providing preventive care services to their enrollees. According to the Group Health Association of America, virtually all established coordinated care plans cover preventive services. (GHAA, 1991) As the amount of care delivered through coordinated care systems increases, more preventive care will be delivered, further benefiting the health care system as a whole.

Consumers are attracted to coordinated care arrangements because, among other things, they encourage the use of primary care services such as prenatal care. Low co-payments in coordinated care arrangements facilitate early access to preventive health services. Defined patient populations in HMOs also allow

programs to target services directly to those who can most benefit from them.

The President's plan establishes coordinated care as the customary method of service delivery in State Medicaid programs. This will increase the numbers of recipients who obtain pre-natal care and other preventive services that will produce savings for the State programs. The expansion of Medicare coordinated care plans will also offer more primary and preventive services to beneficiaries.

Information for Health Purchasing

Personal responsibility is an important element in every aspect of health care. Well-informed employers and consumers can make responsible decisions about their health-related behaviors and about the types of health care coverage that meets their needs. Individuals choosing health plans offering cost-saving preventive care services will be improving their own health status as well as lessening the burden of health care costs to the system as a whole.

VI. MALPRACTICE REFORM

SUMMARY:

- There are direct and indirect costs to the health system attributable to medical malpractice.
- Defensive medical practices constitute the indirect costs to the health care system and are more significant than the direct costs.
- Tort reforms are effective in reducing malpractice insurance premiums.
- Alternative dispute resolution systems show promise for containing costs by improving timeliness of claims resolution and by reducing exorbitant awards.
- The use of practice guidelines and automated health care information will decrease the provision of inappropriate medical services and will reduce medical negligence.

VI. MALPRACTICE REFORM

THE COSTS OF MEDICAL MALPRACTICE

Medical liability creates both direct (premiums) and indirect costs (added, medically unnecessary care) to the health care system.

Direct Costs

During the past decade increased claims frequency along with substantial increases in awards have led directly to increases in the cost of coverage for providers.

The most immediate liability cost for providers is the direct cost of insurance premiums. In the aggregate, malpractice premiums represent about 1% of total health spending. In 1988, the average cost of liability insurance paid by self-employed physicians was $15,900. Obstetricians/gynecologists paid an average of $35,300. (Slora and Gonzales, 1989) According to the American Medical Association, during the mid-eighties, medical liability was the fastest-growing component of physicians' practice expenses, rising at an average annual rate of 21.9%. (Gonzales and Emmons, 1987)

Hospitals and other providers have also felt their malpractice expenses rising in recent years. Some hospitals choose to self-insure, while others purchase commercial insurance. In 1989, the average insurance rates per acute care bed were estimated to be $1,480. (St. Paul Co., 1990) In addition to the costs of insurance coverage there are lesser costs attributable to settling claims beyond those included in the cost of premiums.

Indirect Costs

Although the indirect costs of medical malpractice are harder to quantify, they no doubt represent a larger portion of overall health spending.

Positive defensive medicine. "Positive" defensive medical practices are increases in the intensity of services delivered in a litigious environment.

Positive defensive medicine practices are difficult to quantify, yet any increase in intensity of services, especially services in which the costs are in excess of the benefits, increases overall health care costs.

> A 1987 study estimated the costs of premiums, practice changes in response to liability, and costs of incurring claims. The authors' estimates from two methods were $13.7 and $12.1 billion in 1984, when $75.4 billion was spent

on physicians' services. (Reynolds, Rizzo, and Gonzales, 1987)

Positive defensive medical practices also appear to be widespread. Weisman, Morlock and others reported that 51 percent of physicians in three specialties made changes in their practice in the previous two years as a result of the malpractice litigation climate. These physicians also reported raising their patient fees. (Weisman, Morlock, et. al., 1989)

Negative defensive medicine. "Negative" defensive medical practices are changes in provider behavior in response to litigation fears, such as limiting practices or eliminating certain populations or procedures altogether from a practice.

The non-economic consequences of negative defensive medical practices are potentially profound on health outcomes. Studies show that significant numbers of providers are changing their practices because of their fear of being sued.

In a recent report on increasing access to care by the American College of Obstetricians and Gynecologists (ACOG), the providers themselves listed professional liability as one of the major obstacles to their participation in the Medicaid program. (Feldman, 1991) An ACOG survey in 1990 showed that 12.2 percent of obstetrician-gynecologists quit delivering babies because of liability pressures, and 24.2 percent limited their care of high-risk women. (Opinion Research Corporation, 1990)

In a recent hearing before the Senate Finance Committee ACOG testified that almost 40 percent of Texas family physicians and approximately one-half of Nevada's rural family physicians have stopped delivering babies. (Testimony of ACOG, 1991)

A decrease in negative defensive medical practices will significantly enhance the provisions in the President's plan to increase access to underserved populations.

Provider Perceptions of the Risk of Malpractice

The real risk of a malpractice claim for a provider has increased in recent years. In addition, a study in the State of New York showed that physicians' perceived risks of suit are even three times higher than their actual risks. (Harvard Medical Practice Study, 1990) This inaccurate perception of risk, coupled with our current system of inflated malpractice awards, augments providers' fears of malpractice suits.

THE INDIVIDUAL TAX CREDIT PROGRAM: ESTIMATED COST AND IMPACTS

FINAL REPORT

Prepared For:

The Heritage Foundation

Prepared By:

Lewin/ICF

January 31, 1992

OVERVIEW OF PLAN

- ALL PERSONS ARE REQUIRED TO PURCHASE INSURANCE UNLESS THEY ARE OTHERWISE COVERED UNDER MEDICARE OR MEDICAID. THE MEDICARE AND MEDICAID PROGRAMS ARE RETAINED IN THEIR CURRENT FORM.

- THE TAX EXCLUSION FOR EMPLOYER HEALTH BENEFITS IS REPLACED WITH A REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE PREMIUMS AND UNREIMBURSED MEDICAL EXPENSES.

- THE PRIVATE INSURANCE MARKET WOULD BE REFORMED TO MAKE A STANDARD BENEFITS PACKAGE AVAILABLE TO ALL.

- STATE MANDATED BENEFITS WOULD BE PREEMPTED AND RESTRICTIONS ON MANAGED CARE PLANS WOULD BE ELIMINATED.

FEDERAL RESPONSIBILITY

- EXISTING HEALTH TAX EXPENDITURES ELIMINATED ($77.4 BILLION).
  - -- Federal tax exclusion for employer sponsored health benefits: $66.6 billion
  - -- Federal tax deduction for health expenses over 7.5% of AGI: $ 2.5 billion
  - -- State tax exclusion for employer sponsored health benefits: $ 8.3 billion
- REFUNDABLE TAX CREDIT FOR PREMIUMS AND UNREIMBURSED MEDICAL EXPENSES
  - -- Applies only in months not on Medicare or Medicaid
  - -- IRS rules on countable expenses
- TAX CREDIT VERSION #1
  - -- 80 percent of premiums up to $275 per family member, plus
  - -- 18 percent of premiums over $275 per member, plus
  - -- 18 percent of unreimbursed medical expenses.
- TAX CREDIT VERSION #2

Premiums and Unreimbursed Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10%	21%
10% - 20%	45%
20% or More	65%

a Includes the health care Earned Income Tax Credit (EITC) and deductions for self employed.

FEDERAL RESPONSIBILITY (Continued)

- TAX CREDIT VERSION #3
  - -- 75 percent of premiums up to $275 per family member, plus 14 percent of premiums over $275 plus;

Unreimbursed Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10%	18%
10% - 20%	36%
20% or More	55%

INDIVIDUAL RESPONSIBILITY

- ALL PERSONS NOT OTHERWISE COVERED BY MEDICARE OR MEDICAID ARE REQUIRED TO PURCHASE INSURANCE.

- MINIMUM STANDARD COVERAGE REQUIRED FOR ALL AMERICANS
  - -- $1,000 deductible ($2,000 per family)
  - -- $5,000 cost-sharing maximum

BENEFIT	COINSURANCE
Inpatient Hospital Services (365-day per stay maximum)	80%
Outpatient Hospital Services	80%
Hospital Alternatives (extended or home health care)	Yes
Physician Services	75%
Prenatal/Well-Baby/Well-Child Care	75%
Diagnostic Tests	75%
Prescription Drugs (inpatient)	75%
Emergency Services	100%
Mental Health Care	Not Covered
Dental Care	Not Covered
Vision Care	Not Covered

- AVERAGE MONTHLY COST OF THE PLAN IS $69.33 PER PERSON.

- ACTUARIAL EQUIVALENT ALTERNATIVES ARE PERMITTED.

EMPLOYER RESPONSIBILITY

- EMPLOYERS HAVE THE OPTION OF:
  - -- Continuing to provide health benefits; or
  - -- Discontinuing the health plan
- EMPLOYERS WHO CONTINUE TO PROVIDE BENEFITS:
  - -- The average amount of the employer's contribution is counted as taxable income to the employee[a]
  - -- Employees may not take cash in lieu of coverage.
- EMPLOYERS WHO DISCONTINUE COVERAGE
  - -- Employers must maintain their current level of effort by converting benefits to income
  - -- Employers may facilitate administration by deducting premiums for workers.
- EMPLOYERS WILL HOLD WORKERS HARMLESS FOR THE EMPLOYER SHARE OF INCREASED FICA TAX PAYMENTS DUE TO TAXATION OF BENEFITS.

---

a Separate employer contribution amounts would be used for persons with single and family coverage.

STRUCTURE OF INSURANCE MARKET

- INDIVIDUALS CHOSE AMONG CARRIERS COMPETING ON THE BASIS OF PRICE AND QUALITY.

- CURRENT MARKETING/UNDERWRITING PRACTICES MODIFIED
  - -- In first year of program uninsurable individuals are randomly assigned to carriers.
  - -- In the initial year of the program, insurers must extend coverage to all persons they now cover.
  - -- In coverting employer group coverage to individual or family coverage, premiums are permitted to vary by no more than 25 percent from average premiums within age, sex and geographic groups.

- REFORM OF RENEWAL PRACTICES
  - -- Guaranteed renewal
  - -- Renewal premium updated by carrier-wide average increase
  - -- Changes in renewal premiums due to changes in health status are prohibited.

- STATE MANDATES ARE PREEMPTED BY STANDARD BENEFIT PACKAGE.

- LAWS RESTRICTING SELECTIVE CONTRACTING AND MANAGED CARE PLANS ARE PROHIBITED.

FINANCING

- THE FEDERAL TAX CREDIT WILL BE REVENUE NEUTRAL.
  - -- Tax credit financed by elimination of existing health tax expenditures
  - -- Tax credit levels adjusted to be revenue neutral.

- STATE AND LOCAL GOVERNMENTS WILL TRANSFER TO THE PUBLIC PROGRAM NET SAVINGS IN HEALTH SPENDING TO ASSIST IN FINANCING THE FEDERAL TAX CREDIT.

KEY ASSUMPTIONS

- EMPLOYERS WHO NOW OFFER INSURANCE
  - -- All will discontinue coverage and convert benefits to wages
  - -- All firms that now insure will arrange for payroll deductions to reduce insurance administrative costs.
  - -- Firms with over 1,000 workers are also assumed to establish employee premium financed cafeteria plans to further reduce administrative costs.

- WORKERS NOW COVERED BY EMPLOYER INSURANCE
  - -- Those in poor/fair health will select plans that maintain their existing level of coverage
  - -- Those in good/excellent health will downgrade to the standard package
  - -- Health services utilization for persons who downgrade coverage will decline based upon price elasticities reported in the literature (a price elasticity of -0.2 was selected).

- PERSONS NOW COVERED BY NON-GROUP INSURANCE
  - -- Persons who now have coverage in excess of the minimum standard will maintain that coverage
  - -- Others will upgrade to minimum standard.

- CURRENTLY UNINSURED PERSONS
  - -- All will take the minimum standard package
  - -- Utilization will adjust to levels reported by insured persons with similar characteristics.

- WE ASSUME NO CHANGE IN THE NUMBER OF PERSONS ENROLLED IN MEDICAID.

ADMINISTRATIVE COST ASSUMPTIONS

- ADMINISTRATIVE COSTS WOULD BE THE SAME AS UNDER CURRENT POLICY FOR WORKERS IN FIRMS WHERE THE EMPLOYER ARRANGES EMPLOYEE DEDUCTIONS
- ADMINISTRATIVE COSTS FOR OTHERS PURCHASING INDIVIDUAL INSURANCE WOULD BE 21.9 PERCENT OF CLAIMS. THIS RETENTION RATE WAS ESTIMATED AS FOLLOWS:

ADMINISTRATIVE COSTS FOR INDIVIDUAL COVERAGE AS A PERCENTAGE OF CLAIMS

	Current Policy[a]	Assumed Level Under Tax Credit[b]
Claims Administration	9.3%	8.0%
General Administration	12.5	10.0
Interest Credit	-1.5	-1.5
Risk and Profit	8.5	2.7
Commissions	8.4	0.0
Premium Taxes	2.8	2.7
Total	40.0%	21.9%

a Hay/Huggin estimates of administrative costs for groups with 1 to 4 members under current policy.

b Hay/Huggins estimates of administrative costs for groups with 1 to 4 members under a voluntary risk pooling arrangement adjusted to assure that insurer profits as a percent of claims correspond to the national average observed in the current system.

SOURCE: Congressional Research Service, "Cost and Effects of Extending Health Insurance Coverage," Washington, DC, October 1988.

IMPACT ON NATIONAL HEALTH SPENDING

Table 1
CHANGE IN NATIONAL HEALTH SPENDING BY SOURCE OF PAYMENT
(In Billions)

		Change in Spending
IMPACT ON PAYORS		
Household Payments		129.9[a]
Premium Payments	88.2	
Out-of-Pocket Spending	62.7	
Tax Credits	(84.9)	
Eliminate Tax Exclusion	63.9	
Private Employers[b]		(112.4)
Federal Government[b]		(5.1)
State Governments[c]		(23.2)
NET CHANGE IN HEALTH SPENDING		
Changed in Health Spending		(10.8)
Utilization for Newly Insured	8.9	
Utilization for Currently Insured	(21.8)	
Insurer Administrative Costs	2.1	

a The increases in household health spending will be offset by increased wages of $148.7 billion.

b Reflects elimination of employee coverage. Employer savings in health spending will be offset by increases in wages not shown here.

c Reflects elimination of employee coverage and savings to county hospitals.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

IMPACT ON FEDERAL SPENDING

Table 2
SOURCES AND USES OF FEDERAL FUNDS UNDER THE TAX CREDIT PROGRAM IN 1991
(in billions)

SOURCES OF FUNDS		USES OF FUNDS	
Elimination of Tax Exclusion	$66.6	Tax Credits	$84.9
Federal Income Tax 39.7 OASDI Payroll Tax 21.2 HI Payroll Tax 5.7		Civil Service Plan Health Benefits (4.6) Wages 4.6 OASDI and HI Taxes 0.5	0.5
Eliminate Deduction for Health Expenditures in Excess of 7.5 Percent of AGI	2.5	Corporate Income Tax Loss[a]	2.5
Contribution from State and Local Governments	18.8		
Total Sources of Funds	$87.9	Total Uses of Funds	$87.9

a We assume that the full amount of the employer share of the increase in OASDI and HI payroll taxes is absorbed by employers as reduced profits resulting in a change in corporate income tax payments.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

IMPACT ON STATE AND LOCAL SPENDING

Table 3
SOURCES AND USES OF STATE FUNDS UNDER THE TAX CREDIT PROGRAM IN 1991
(in billions)

CHANGES IN REVENUES		CHANGES IN EXPENDITURES	
Elimination of State Income Tax Exclusion[a]	$8.3	Public Hospitals	$(13.2)
Premium Taxes[b] Current Revenues 1.6 Revenues Under Policy 1.5	(0.1)	State and Local Worker Benefits Health Benefits (23.8) Wages 23.8 OASDI and HI Taxes 2.0	2.0
State Corporate Income Tax Loss	(0.6)	Contribution to Federal Tax Credit	18.8
Net Change in Revenues	$7.6	Net Change in Expenditures	$ 7.6

a The increase in wages under the program will result in an increase in state income tax payments.

b Premium tax revenues decline due to the reduction in health insurance coverage under the tax credit program.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

IMPACT ON EMPLOYER SPENDING

Table 4
CHANGE IN PRIVATE EMPLOYER HEALTH SPENDING UNDER THE TAX CREDIT PROGRAM IN 1991
(in billions)

	Change in Spending
Current Employer Expenditures for Health care[a]	$124.3
Convert Employee and Dependent Benefits to Wages[b] Benefit Payments (120.2) Wages 120.2	0.0
OASDI and HI Tax on Benefits (Employer Share)	10.9
Change in Employer Costs	10.9
Change in Corporate Taxes	(3.1)
Net Change in Employer Costs (Change in Costs Per Worker of $104.8)	$7.8

a Includes the employer share of expenditures for workers, dependents and retirees.

b Employer contributions for worker and dependent benefits are converted to wages. Retiree coverage is assumed to be retained.

c The entire amount of the increase in OASDI and HI payroll taxes is assumed to be absorbed by employers as reduced profits resulting in a change in corporate income taxes.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

IMPACT ON HOUSEHOLD HEALTH SPENDING

Table 5
CHANGE IN HOUSEHOLD HEALTH SPENDING
(In Billions)

Health Spending		
Premium Payments		$ 88.2
Employee Contribution in Employer Plans	(45.2)	
Individual Premium Payments	133.4	
Out-of-Pocket Expenses		62.7
Tax Credit		(84.9)
Eliminate Tax Expenditures (individual share)		61.4
Federal	53.1	
State	8.3	
Eliminate Health Expense Deduction (over 7.5% AGI)		2.5
Net Change in Health Spending		129.9
WAGE EFFECT		
Increased Wages (offset to change in health spending)		(148.7)
Net Impact on Households		$(18.8)

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 6
FAMILIES BY ANNUAL OUT-OF-POCKET EXPENSES AND PREMIUM PAYMENTS UNDER CURRENT LAW IN 1991[a,b]

Total Out-of-Pocket Expenses and Premiums	Families (millions)	Total Family Spending (billions)
0 - 500	4.3	$ 0.4
500 - 1,000	8.5	6.7
1,000 - 2,500	18.8	32.5
2,500 - 5,000	28.2	103.3
5,000 - 10,000	15.1	100.3
10,000 - 20,000	2.0	24.1
20,000 - 30,000	0.1	2.3
30,000+	0.1	4.0
TOTAL	77.2	$273.7

a Includes premiums and direct payments for care before tax credits.

b Includes families where the household head is under age 65.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

DISTRIBUTIONAL IMPACT OF ALTERNATIVE TAX CREDIT FORMULAS

FEDERAL TAX CREDIT ALTERNATIVES

- TAX CREDIT VERSION #1
  - -- 80 percent of premiums up to $275 per family member, plus
  - -- 18 percent of premiums over $275 per member, plus
  - -- 18 percent of unreimbursed medical expenses.

- TAX CREDIT VERSION #2

Premiums and Unreimbursed Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10%	21%
10% - 20%	45%
20% or More	65%

FEDERAL TAX CREDIT ALTERNATIVES
(Continued)

- TAX CREDIT VERSION #3
  - -- 75 percent of premiums up to $275 per family member, plus 14 percent of premiums over $275, plus

Unreimbursed Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10%	18%
10% - 20%	36%
20% or More	55%

Table 7
FEDERAL AND STATE TAX CREDIT AMOUNTS UNDER ALTERNATIVE FORMULAS IN 1991
(in billions)

Federal Tax Credit Formula	TAX CREDIT AMOUNT	
	Before Budget Neutral Adjustment	After Budget Neutral Adjustment*
Version #1	$104.9	$84.9
Version #2	100.1	84.9
Version #3	$115.9	$84.9

* All analyses reflect budget neutral adjustments to the tax credit formula.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 8
AVERAGE NET IMPACT OF ALTERNATIVE TAX CREDIT OPTIONS ON FAMILIES BY FAMILY INCOME 1991[a]

		FAMILY INCOME								
	All Households	Less Than $10,000	$10,000-$14,999	$15,000-$19,999	$20,000-$29,999	$30,000-$39,999	$40,000-$49,999	$50,000-$74,999	$75,000-$99,999	$100,000 or More
Household health spending under current law	$1,841	$887	$1,223	$1,428	$1,638	$2,106	$2,954	$2,795	$3,000	$3,738
CHANGES IN HEALTH SPENDING										
Change in premium payments[b]	1,314	671	930	991	1,100	1,279	1,312	1,459	1,679	1,814
Change in out-of-pocket payments for care	692	108	286	367	519	769	998	1,059	1,053	1,176
Elimination of state and federal tax expenditures[c]	745	35	154	283	500	736	875	1,130	1,397	1,492
WAGE EFFECTS										
Increased wages (counted as an offset to health spending)	(1,767)	(162)	(657)	(1,119)	(1,531)	(2,060)	(2,313)	(2,681)	(2,754)	(2,770)
TAX CREDITS (FEDERAL AND STATE)										
Version #1	(1,052)	(472)	(669)	(810)	(959)	(1,222)	(1,242)	(1,368)	(1,395)	(1,510)
Version #2	(1,052)	(734)	(871)	(970)	(1,045)	(1,230)	(1,168)	(1,141)	(1,087)	(1,170)
Version #3	(1,052)	(536)	(724)	(853)	(966)	(1,245)	(1,234)	(1,289)	(1,298)	(1,408)
CHANGE IN AFTER-TAX HEALTH SPENDING NET OF AFTER-TAX CHANGE IN INCOME										
Version #1	(168)	210	44	(288)	(371)	(498)	(378)	(193)	(20)	242
Version #2	(168)	(82)	(158)	(456)	(457)	(534)	(304)	(26)	293	574
Version #3	(168)	126	(11)	(331)	(370)	(521)	(370)	(122)	77	344

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation.
b Includes individual premium payments less employer contributions to employer plans eliminated under the tax credit proposal.
c Includes the additional taxes paid on employer benefits converted to income including, federal income taxes, the employee share of OASDI and HI payroll taxes, and state income taxes.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 9
DISTRIBUTION OF FAMILIES BY CHANGE IN HEALTH SPENDING NET OF CHANGES IN AFTER TAX INCOME UNDER THE TAX CREDIT PLAN IN 1991[a,b]

Change in Health Spending Net of Changes in Income[c]	TAX CREDIT MODEL		
	Version #1	Version #2	Version #3
Net Increase of $20 or More	42.2%	45.2%	43.4%
$1,000 or More Increase	17.3	17.7	17.7
$500 - $999 Increase	9.0	11.8	9.3
$250 - $499 Increase	9.4	8.6	10.0
$100 - $249 Increase	4.4	4.5	4.0
$20 - $ 99 Increase	2.1	2.6	2.4
No Net Change (change of less than $20)	3.9%	3.7	3.6
$20 - $ 99 Decrease	4.0	4.1	3.8
$100 - $249 Decrease	5.5	6.0	5.6
$250 - $499 Decrease	8.2	9.0	8.5
$500 - $999 Decrease	13.2	12.1	13.1
$1,000 or More Decrease	23.1	19.7	21.8
Net Decrease of $20 or More	54.0%	50.9	52.8
All Families	100.0%	100.0%	100.0%

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

b Includes only families with head under age 65.

c Includes the increase in wages under the program less the net change in household health spending including: changes in premiums and out-of-pocket spending; taxes on increased wages; and tax credits.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 10
(Tax Credit - Version #1)

DISTRIBUTION OF FAMILIES BY THE AMOUNT OF THE CHANGE IN TOTAL FAMILY HEALTH CARE EXPENSES FOR PREMIUMS AND OUT-OF-POCKET COSTS (INCLUDES ONLY FAMILIES WITH HEAD UNDER AGE 65)[a]

		PERCENT OF ALL FAMILIES BY TOTAL FAMILY INCOME										
		Increase in Family Health Costs						Reduction in Family Health Costs				
Family Income	All Families	1,000+	500-999	250-499	100-249	20-99	No Change	20-99	100-249	250-499	500-999	1,000+
<$10,000	100.0%	10.8%	13.6%	23.0%	3.1%	1.0%	18.0%	10.2%	6.2%	4.4%	4.4%	5.3%
$10k-$14,999	100.0	17.7	14.8	15.5	2.0	1.1	4.5	6.0	5.0	6.5	10.4	16.3
$15k-$19,999	100.0	15.5	7.8	10.8	3.6	2.5	3.0	3.5	5.3	10.5	17.1	20.4
$20k-$29,999	100.0	16.3	8.3	8.1	4.3	2.1	1.4	1.9	7.7	10.0	15.9	23.9
$30k-$39,999	100.0	16.1	8.4	5.8	6.2	2.3	0.7	2.4	4.7	8.0	11.8	33.5
$40k-$49,999	100.0	18.3	5.9	4.8	5.4	3.0	1.6	2.6	5.7	7.3	14.1	31.2
$50k-$59,999	100.0	20.1	6.8	4.5	4.4	2.5	1.1	2.2	4.6	10.0	16.3	27.4
$75k-$100,000	100.0	20.0	6.9	4.5	6.2	2.6	0.0	4.1	5.2	8.8	16.0	25.8
$100,000+	100.0	26.9	11.0	8.2	2.9	1.2	0.0	2.7	3.7	7.0	15.1	21.3
TOTAL	100.0	17.3	9.0	9.4	4.4	2.1	3.9	4.0	5.5	8.2	13.2	23.1

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM)

Table 11
(Tax Credit - Version #2)

DISTRIBUTION OF FAMILIES BY THE AMOUNT OF THE CHANGE IN TOTAL FAMILY HEALTH CARE EXPENSES FOR PREMIUMS AND OUT-OF-POCKET COSTS (INCLUDES ONLY FAMILIES WITH HEAD UNDER AGE 65)[a]

		PERCENT OF ALL FAMILIES BY TOTAL FAMILY INCOME										
		Increase in Family Health Costs					No Change	Reduction in Family Health Costs				
Family Income	All Families	1,000+	500-999	250-499	100-249	20-99		20-99	100-249	250-499	500-999	1,000+
<$10,000	100.0%	5.3%	13.7%	15.7%	5.7%	2.4%	15.7%	9.7%	7.3%	8.0%	8.0%	8.5%
$10k-$14,999	100.0	13.8	25.2	4.2	4.5	3.3	3.9	4.4	5.2	6.5	9.7	19.5
$15k-$19,999	100.0	13.0	12.2	8.5	3.2	2.5	2.4	4.2	5.9	12.7	13.7	21.7
$20k-$29,999	100.0	14.5	11.7	8.1	3.0	2.5	2.5	3.8	6.4	9.2	15.5	22.7
$30k-$39,999	100.0	16.8	9.7	8.2	5.1	2.4	1.5	2.1	5.5	7.7	12.9	28.2
$40k-$49,999	100.0	19.9	8.2	9.2	5.0	2.7	0.8	3.2	5.4	8.1	15.3	22.2
$50k-$59,999	100.0	23.8	10.1	6.9	5.0	1.8	1.0	2.6	5.9	12.2	10.4	20.2
$75k-$100,000	100.0	25.6	10.1	7.1	4.6	4.1	1.6	2.5	6.1	7.6	14.4	16.3
$100,000+	100.0	37.5	9.6	5.2	2.4	4.7	0.7	3.8	4.6	4.7	9.7	17.2
TOTAL	100.0	17.7	11.8	8.6	4.5	2.6	3.7	4.1	6.0	9.0	12.1	19.7

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 12
(Tax Credit - Version #3)

DISTRIBUTION OF FAMILIES BY THE AMOUNT OF THE CHANGE IN TOTAL FAMILY HEALTH CARE EXPENSES FOR PREMIUMS AND OUT-OF-POCKET COSTS (INCLUDES ONLY FAMILIES WITH HEAD UNDER AGE 65)[a]

		PERCENT OF ALL FAMILIES BY TOTAL FAMILY INCOME										
		Increase in Family Health Costs						Reduction in Family Health Costs				
Family Income	All Families	1,000+	500-999	250-499	100-249	20-99	No Change	20-99	100-249	250-499	500-999	1,000+
<$10,000	100.0%	9.5%	12.6%	21.1%	3.9%	2.3%	16.1%	9.4%	6.2%	6.3%	6.0%	6.7%
$10k-$14,999	100.0	16.6	15.1	15.9	1.9	2.5	4.0	5.2	4.8	7.0	10.4	16.6
$15k-$19,999	100.0	15.1	8.5	11.5	3.9	2.7	2.3	3.8	5.2	10.9	16.8	19.5
$20k-$29,999	100.0	16.1	9.0	7.6	5.0	1.6	0.9	3.5	7.7	10.2	14.5	23.8
$30k-$39,999	100.0	16.6	9.5	8.3	4.0	2.1	1.2	2.5	5.2	7.9	11.2	31.6
$40k-$49,999	100.0	19.6	5.6	6.2	6.0	3.5	0.8	1.8	7.2	5.1	15.9	28.5
$50k-$59,999	100.0	21.3	7.4	6.0	3.3	3.2	1.2	2.8	4.1	10.4	16.6	23.6
$75k-$100,000	100.0	21.5	6.9	8.1	4.4	1.5	1.9	2.4	4.5	10.3	14.9	23.4
$100,000+	100.0	30.6	12.0	5.3	2.7	1.3	1.5	0.9	5.6	8.3	11.0	20.7
TOTAL	100.0	17.7	9.3	10.0	4.0	2.4	3.6	3.8	5.6	8.5	13.1	21.8

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM)

Table 13

CHANGE IN AVERAGE FEDERAL TAX BENEFITS PER FAMILY BY FAMILY INCOME UNDER THE TAX CREDIT PLAN IN 1991

		NET CHANGE IN TAX BENEFITS		
	Current Tax Exclusion	Tax Credit Version #1	Tax Credit Version #2	Tax Credit Version #3
Family Income				
Less Than $10,000	$ 50	$372	$684	$476
$10,000 - $14,999	207	462	664	517
$15,000 - $19,999	366	444	612	487
$20,000 - $29,999	594	365	451	372
$30,000 - $39,999	857	365	401	388
$40,000 - $49,999	986	256	182	248
$50,000 - $74,999	1,373	(13)	(232)	(84)
$75,000 - $99,999	1,427	(32)	(345)	(129)
$100,000 or More	1,463	47	(285)	(55)
All Families[a]	$ 802	$250	$250	$250

a Includes federal income taxes and the employer and employee share of the OASDI and HI payroll taxes.
b The tax credits are structured to be budget neutral.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

PREPARED STATEMENT OF JOHN D. MOYNAHAN, JR.

TRADE-OFFS AND CHOICES: HEALTH POLICY OPTIONS FOR THE 1990S

Good afternoon. My name is Jack Moynahan. I am the Executive Vice-President responsible for group operations at Metlife in the United States. I accompanied today by Mr. Robert Leitman, Senior Vice President of the Louis Harris organization.

The findings we present today are a brief summary of a study we released last spring. The survey included 84 questions, many of which had several alternatives as possible responses and the full printed report runs approximately 100 pages. While this report was released about one year ago, it remains the only comprehensive survey of leadership attitudes about trade-offs and choices for health care reform. We encourage you to read the full report and not rely only on the summary we are limited to presenting at this hearing.

INTRODUCTION

Virtually everyone agrees that America's health care system needs important change. Several public opinion polls have been taken recently, all giving that clear message. When need for change and reform is generally recognized, it's valuable to know the opinions, not only of the general public, but especially of key health care leaders—those in a position to effect change, and upon whom we will, in fact, ultimately rely, to improve the American health care system.

To move discussion and debate forward toward consensus and action, compromises, trade-offs and choices by those leaders will have to be made. In the process, most stakeholders in our current system will almost certainly have to settle for less than they insist upon today.

PURPOSE OF STUDY AND METHODOLOGY

It was with this in mind that we undertook this project: our purpose was to make available as reliable a database as we could, to define leadership positions on key issues as they currently stand, and to explore what trade-offs might be available to help the nation reach the common ground on which an improved health care system can be built.

We commissioned Louis Harris and Associates to conduct a survey of more than 2,000 leaders: 1,175 senior executives of both large and small corporations, 260 Federal legislators, 25 key legislative committee staff, 15 Health and Human Services and Health Care Financing Administration senior executives, 50 union leaders, 201 physician leaders, 251 hospital CEOs, 50 state representatives, and 21 senior executives of major health insurers.

The survey was designed to get people thinking about accommodation within the health care system and to react to at least some avenues along which agreement might be reached. The largest samples—corporate executives, Federal legislators and hospital CEOs—are systematic probability samples. The smaller samples represent a high percentage of all possible respondents. In other words, a very large percentage of those within a stakeholder group who could have been interviewed *were*. 2,048 telephone interviews were conducted, each taking approximately 30 minutes.

It is worth noting the unique aspects of the survey. It's more involved than the title "Trade-offs and Choices" suggests, though this concept is at the heart of the study. In addition to being a large survey, in its total, nine *different* groups of respondents were involved. One can think of the study, therefore, as a series of nine separate ones, which allows comparison and contrast within and across stakeholder groups.

In addition to the Harris organization, represented by Humphrey Taylor and Bob Leitman, we enlisted the aid of several independent authorities on health policy to critique the survey questions and help us maintain objectivity. For their help, we thank Eli Ginzberg, of Columbia University; Dr. Robert J. Glaser, Trustee and Director of Medical Science for the Lucille P. Markey Charitable Trust; John Iglehart, Editor of *Health Affairs;* and Edward Connors, former Chairman of the Board of the American Hospital Association.

In the conduct of the survey, the stakeholders—each representing a different perspective—were asked questions in order to construct a brief assessment of their views on the U.S. health care system. Respondents were then probed further to uncover how change within the system might occur, and further still, to discern each stakeholder's willingness to compromise on specific issues.

The "trade-off" questions were asked after a preamble which included the words, "If it were part of a program where each group would make some concessions in

order to reach a consensus, . . . " and then the question was posed. The willingness of respondents to accept compromises and trade-offs must be interpreted in that context. Their expressed willingness to accept a proposal does not necessarily mean they favor it.

While we believe this study to be important, we don't hold it out a definitive. Much more can be done to develop sound information to help in the national debate, and we encourage that. We encourage concerned persons to analyze the data independently, to work it if you will, and use it along with data from other studies already done and yet to be done and to collaborate in creating a world leading health care system on which we can all rely with confidence.

ATTITUDES ABOUT CHANGE

This section of the survey examined stakeholders' underlying values and assumptions about the nation's health care system and probed for the type of system stakeholders agree is needed. It also measured their willingness to help improve the system. Majorities of all stakeholder groups expressed the opinion that changes are necessary to make the health care system work better.

On this issue of needed reform, stakeholders were asked if in their view the health care system, first, works pretty well and only minor changes are necessary, or alternatively, if fundamental changes are required. Apart from 31% of physician leaders, no more than 14% of any group felt the current system requires only minor changes. There is overwhelming support among all groups for fundamental change. Over 80% of all groups, with the exception of physicians who support fundamental change by a 68% majority, feel the system needs fundamental change.

Having established that the system is in need of fundamental change, Harris next probed stakeholders on the nature of such change and learned not only that reform should occur, but that reform is seen as very likely to occur. They also found that eight of the nine stakeholder groups believe change should come incrementally. Only unions feel change should be comprehensive and rapid.

Large majorities of all stakeholder groups agree that everyone will have some kind of health insurance coverage. This finding may be the single strongest finding of the survey and brings us to what everyone generally agrees is the issue: balancing access and cost in the health care system.

REFORM THROUGH TRADE-OFFS: FINANCING AND BENEFITS

A key objective of the survey was to uncover the trade-offs stakeholders would be willing to make as part of a total plan in which everyone gave up something to ultimately improve the system. It seems likely that changes, particularly any major changes in coverage or cost containment, will inevitably involve compromises by several, if not all, the major groups surveyed.

When each group was asked if compromise was acceptable to achieve health care reforms, all groups said *"yes"* they *are* willing to compromise. Very large majorities of physician leaders, insurers, hospital CEOs, union leaders, and corporate executives all believe that their own groups should be willing to compromise to achieve viable reforms.

The first trade-off issue to examine is a practical one: how to pay for universal coverage. One way to finance reform is to reallocate existing resources. Stakeholders were asked if the additional cost of covering 31 million uninsured meant $50 billion less spent on other goods and services—would they favor or oppose such a reallocation? Majorities of most groups favor such a reallocation to cover the uninsured.

An alternative to reallocating resources is to raise more revenues. Stakeholders were asked, if it were part of a program in which all made compromises to reach a consensus, how acceptable would higher income taxes be? Higher taxes were *more* acceptable than reallocation of existing funds. More than 65% of all groups found payment of higher income taxes acceptable but corporate executives (at 57%) find higher income taxes less acceptable than other groups. By the way, keep in mind these respondents are sophisticated individuals who likely understand the magnitude of the taxes required.

To probe the acceptability of the tax question even further, corporate CEOs were asked for their attitudes on payroll taxes. We find that, regardless of size, CEOs are overwhelmingly opposed. Even though they find higher income taxes less acceptable to them than other groups, income taxes are *more* acceptable than payroll taxes as a method of raising revenues.

To learn the acceptability of taxing insurance premiums we asked stakeholders if, again as part of a total plan in which each group would make concessions, they would be willing to paying income tax on health care premiums paid by employers.

Results were somewhat mixed. Five of the nine groups said it's acceptable. Four oppose the idea, and legislators are split. Interestingly, corporate CEOs and union leaders, who frequently do not agree, are together in leading opposition to this option. (See Attachment A: Taxing Employer Paid Premiums.")

Another approach to reforming the system is to examine the benefit plan. One way to make coverage available to increased numbers of people is to address cost by modifying the scope and level of benefits. When asked their opinion of having to pay a substantially higher portion of the cost of health care services out-of-pocket, majorities in 7 of the 9 groups said cost-sharing is acceptable as part of a total plan in which everyone makes compromises. We should note, however, the very strong opposition of union leaders to this approach.

While most union leaders find cost-sharing *unacceptable*, they do say they *are* willing to enter into cooperative ventures with management if savings are used for wage increases, improved competitiveness of their companies, or shared equally between the two. (See Attachment B: "Unions Will Work With Management If Savings are Used For:")

Again, as part of a total plan in which everyone makes compromises, Harris asked stakeholders how acceptable it would be to be required to obtain care as a member of a managed care plan, specifically such as an HMO, as one way of making health insurance more affordable. Majorities of all groups said that having to obtain care as a member of an HMO is acceptable. While union leaders voiced opposition to out-of-pocket-cost-sharing, managed care appears quite acceptable. (See Attachment C: "Acceptability of Managed Care.")

Consistent with stakeholders attitudes about mandatory managed care, the idea of being a member of a health plan that limits members to the most cost-effective providers, and excludes other providers, is also acceptable to large majorities. Interestingly, although consumers were not interviewed in this survey, respondents here, when asked, agreed that the consumer will be a tough sell when it comes to limiting their range of choice of doctors.

Respondents were also surveyed about a variety of other potential changes in benefit plan design. In this series of questions, we learned that stakeholders agree that having to obtain a primary care doctor's approval for referral to specialty care is acceptable. Reactions to the idea of waiting several months for non-mergency elective surgery are mixed. Five groups found this acceptable. Union leaders are equally divided. And three found it unacceptable: physicians, insurers, Federal legislators. Being a member of a health plan which does not cover certain expensive procedures and treatments is another issue on which no consensus emerges, but which slim majorities in 7 groups find acceptable. Except for union leaders, who are equally divided, majorities of all other groups believe it will be necessary to somehow ration high-tech services.

One way to make health *insurance* more affordable is to make health care more affordable. This section examines trade-offs which physician leaders and hospital chief executives said they are willing or unwilling to accept as part of a plan in which every group makes concessions.

PHYSICIAN TRADE-OFFS

First, let's focus on physicians, who are in the front lines in the delivery of care. Physician leaders found these items acceptable: (1) being required to generally follow practice guidelines on how to treat different conditions; (2) requiring patients to obtain the prior approval of a primary care doctor in order to see specialists for non-emergency care; and (3) being compensated on a fee-for-service basis, but entirely from a fixed budget with an expenditure cap. (See Attachment D: "Physicians Will Accept.")

What was *not acceptable* were other types of reimbursement mechanisms that doctors apparently feel intrude more on their practice. These include: (1) having a uniform national fee schedule for all health plans, public and private, with no balance billing allowed; (2) being compensated only on a capitated basis; and (3) being compensated on a purely salaried basis. (See Attachment E: "Physicians Will Not Accept.")

For more autonomy, however, physicians are willing to give up a portion of their income in exchange for fewer complications and less "outside interference" in their practices. Specifically, very large majorities would be willing to trade a 10% reduction in income in return for any one of these: (1) a substantial reduction in paperwork; (2) malpractice reform with limits on punitive damages and damages for pail and suffering; or (3) substantially increased autonomy with less utilization review and less regulation. (See Attachment F: "10% Less Income for Less 'Hassle.'")

Interestingly, when asked to accept national health insurance with these same three benefits, *plus* guaranteed payment of fees, but be required to negotiate fees with the government, physicians refused. Sixty-three percent say they are not willing to accept such a system.

HOSPITAL TRADE-OFFS

Hospital CEOs were surveyed about the acceptability of various trade-offs for them. Recognizing that capital expenditures have been more or less regulated for hospitals for over twenty years, hospital CEOs, by a two to one margin, said that even tougher constraints on capital expenditures are acceptable. On several other issues, hospital CEOs expressed a willingness to control costs by: (1) treating all patients even if reimbursement is below their cost; (2) accepting global budgets, or a pre-set total annual hospital budget, a method used in many foreign countries; and (3) accepting a uniform one-payer system with prospective payment fees for all health plans, public and private. (See Attachment G: "Hospital CEOs Will Accept.")

As to what hospital chief executives will not accept, the specific question posed pertained to two well known special aspects of hospital finance. Not surprisingly, hospital CEOs, by more than three to one, find *unacceptable* any loss of tax-exempt status or the right to issue tax-free bonds or the loss of separate Medicare reimbursement for their capital expenses. (See Attachment H: "Hospital CEOs Will Not Accept.")

INSURER TRADE-OFFS

In the context of a better system for all, insurers were asked about their willingness to change the way in which they write insurance for small businesses where access has proved to be a systematic problem. To the extent a reinsurance mechanism is available to spread the cost of excess losses, the insurance companies show a very strong willingness to provide insurance on a guaranteed renewable basis, to somehow guarantee issue of insurance regardless of health status, and to change other underwriting practices for the small case market, such as the use of pre-existing condition limitations. Insurers also seem to agree overwhelmingly (74%) that operating on some form of community rating for all health insurance risks in the small case market is acceptable. (See Attachment I: "Insurers Will Accept With Reinsurance Mechanism.")

CORPORATION TRADE-OFFS

Again, a part of a total plan in which everyone makes concessions, corporations and, surprisingly, even the larger size employers, also showed willingness to accept community rating for the health benefit programs of their employees.

Majorities of corporate executives in this survey agreed that being required to provide a basic health insurance benefit to all full-time employees and dependents was acceptable. Of particular note is the willingness of even the smallest employers surveyed to consider this acceptable in a trade-off situation. Corporate CEOs also seemed generally willing, though not quite as much, to be required to provide health insurance benefits to retirees under 65 who are not yet eligible for Medicare. (See Attachment J: "Corporations Will Accept Mandated Coverage for Full-Timers.")

On the other hand, corporate CEOs generally felt that it is not acceptable that they be required to provide health insurance coverage to part-timers, defined as those working at least 20 hours a week. Interestingly, CEOs of businesses with 10,000 or more employees, found the concession slightly acceptable.

UNIVERSAL COVERAGE ISSUES

Probing as to corporations' attitudes on national health insurance, we asked the question: "If the only way to prevent the introduction of a national health insurance system is for employers to introduce a much more aggressively managed care plan with less freedom of choice and higher cost sharing, how willing would you be to introduce such a plan for all your employees?" The majority, even among the smaller employers, are willing to take that course of action, rather than adopt a national plan.

Probing further on the expected effects of public/private universal coverage or government universal coverage, stakeholders were asked, first, to assume we adopted a public/private system in which employers are mandated to provide health insurance to employees and dependents and the government insures all the unemployed. Given that scenario, what were their expectations as to the effect on costs and quality of care. Majorities said both would increase. Cost would go up, but so would quality. When asked the same question with respect to a government health insur-

ance system, stakeholders agreed that cost would increase under such an alternative. With the exception of union leaders, however, everyone else believed that the quality of health services would deteriorate.

Given that all stakeholders find universal coverage to be the highest priority for change, the issue is how to achieve that coverage, while balancing the realities of cost and the scarcity of funding. A number of plans have been proposed. For the most part, they fall into three categories. Harris asked the stakeholders to look ahead 10 years and say which of three alternatives is most likely in their view. We learned that only a small minority of stakeholders feel the current system of private health insurance, mostly through employers, plus Medicare and Medicaid, will remain in place through the year 2000.

In a series of questions, Harris became more specific and defined two changes which could be made to modify the system: the present arrangement modified by a law requiring mandatory employer-provided health insurance with government providing insurance to all the unemployed, or alternatively a comprehensive government health insurance program covering everyone—"national health insurance."

Of those expecting fundamental change, very strong majorities in seven of the nine stakeholder groups expect the fundamental change to take the form of the present system with two modifications. Notably, while the majorities agree with the other, a significant minority percentage of both unions and corporate CEOs think a government health insurance program likely.

When asked if they agree or disagree that our health insurance system should continue to operate largely through employment-based plans, a majority in all but one stakeholder group agreed. Union leaders, however, are equally divided on this issue.

We asked if stakeholders thought the appropriate role for the Federal government in the future of the health care system should be as a manager and administrator or rather, more as a rulemaker setting the rules for the private sector. Majorities of all groups except for union leaders, who were roughly equally split, believe that the Federal government's role in the future health care system should be to serve as rulemaker, setting the rules for the private sector rather than manager.

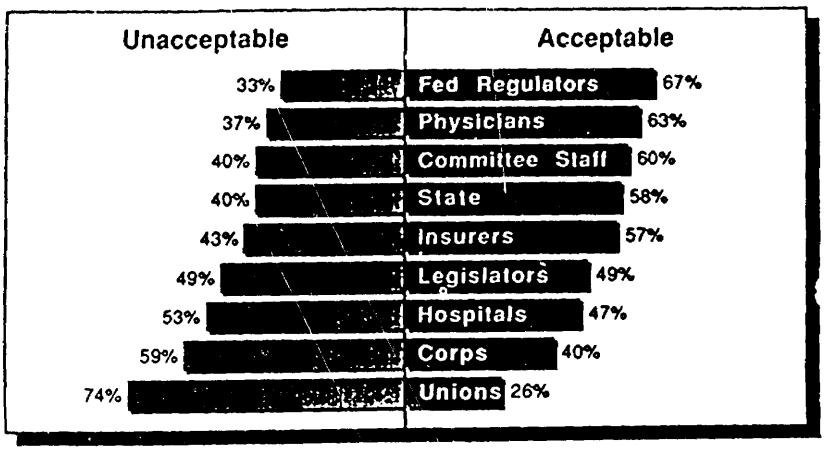
Since the task of improving the health care system has so many different dimensions, Harris asked, in a further series of questions specifically who should have *principal* responsibility for ensuring access, for containing costs, and for assuming the quality of health care services. Principal responsibility for improvements in access and cost containment was seen as belonging to government. On quality issues principal leadership was sought from physicians' organizations, the hospital industry and the Federal government.

CONCLUSION

What we find most important are the following points: (1) change is needed; (2) there is strong agreement among them that change is likely; (3) there is agreement that change is best made incrementally; and (4) there is a clear willingness among them to compromise to create a better system for all Americans.

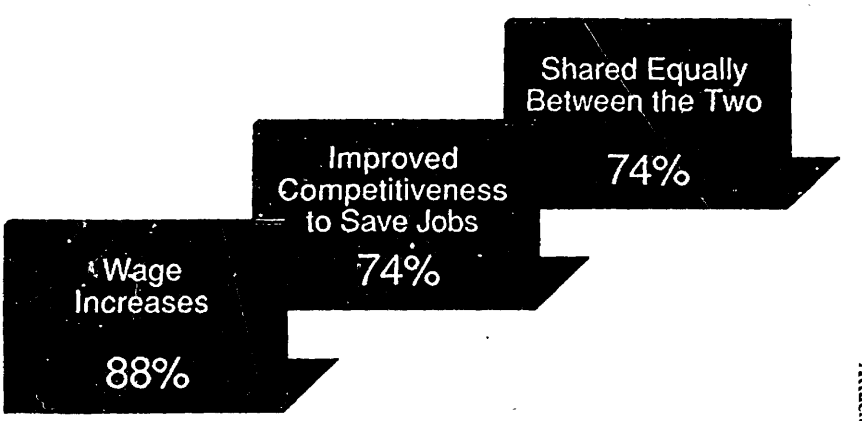
We find that most encouraging and hope you do as well. We also hope the findings of this survey can help in bringing these expectations to reality.

Taxing Employer Paid Premiums



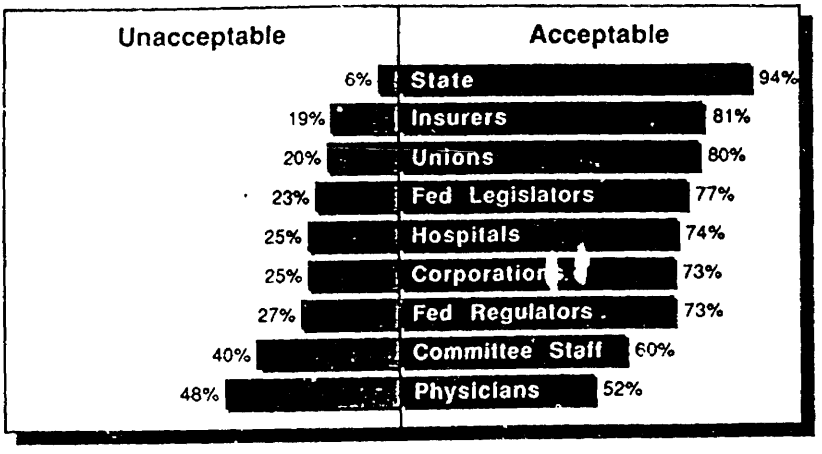
Attachment A

Unions Will Work with Management If Savings Are Used For:



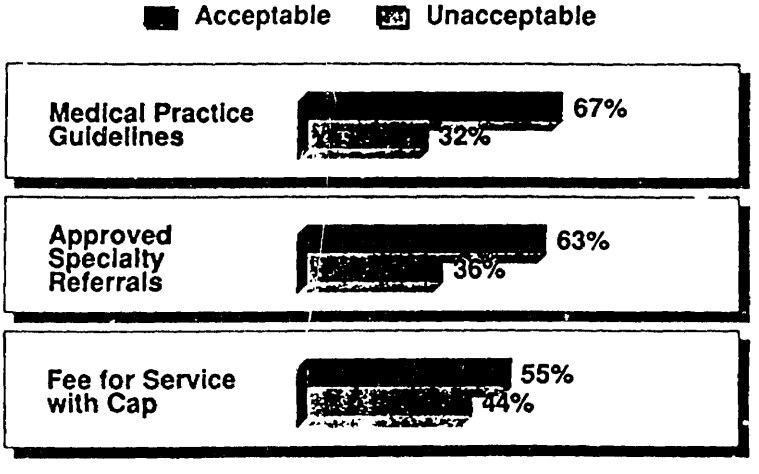
Attachment B

Acceptability of Managed Care



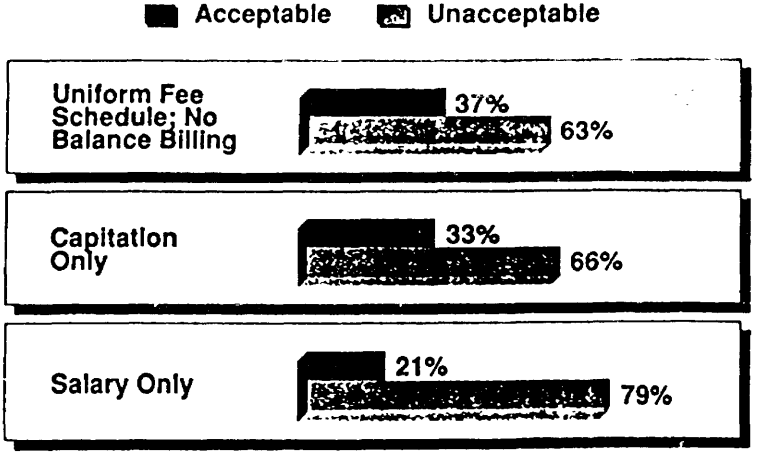
Attachment C

Physicians Will Accept



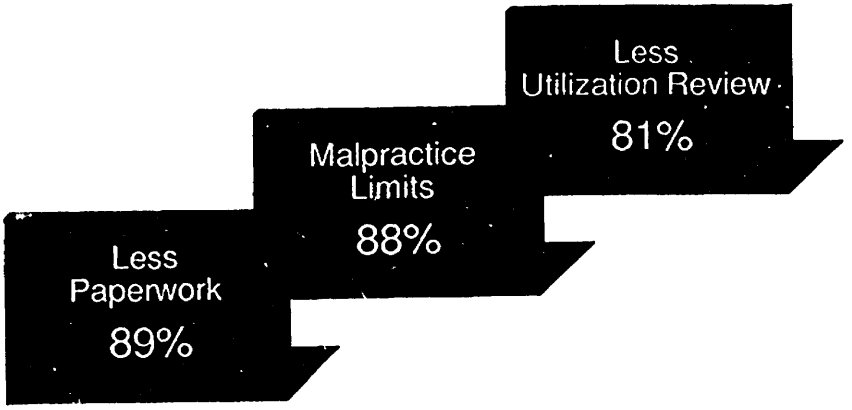
Attachment D

Physicians Will Not Accept



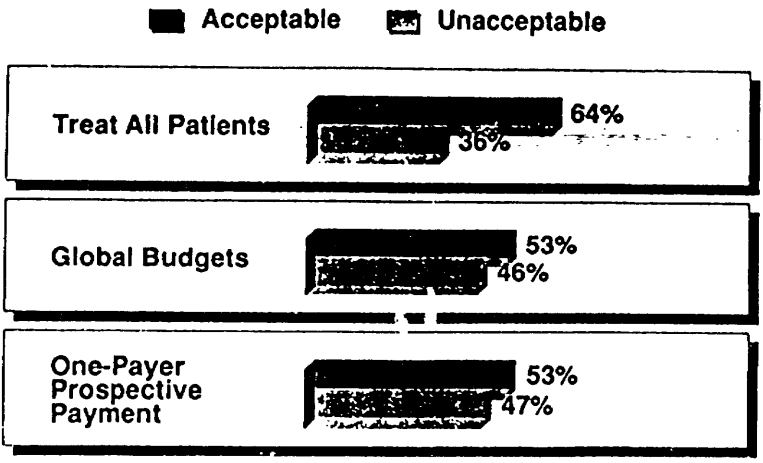
Attachment E

10% Less Income for Less "Hassle"



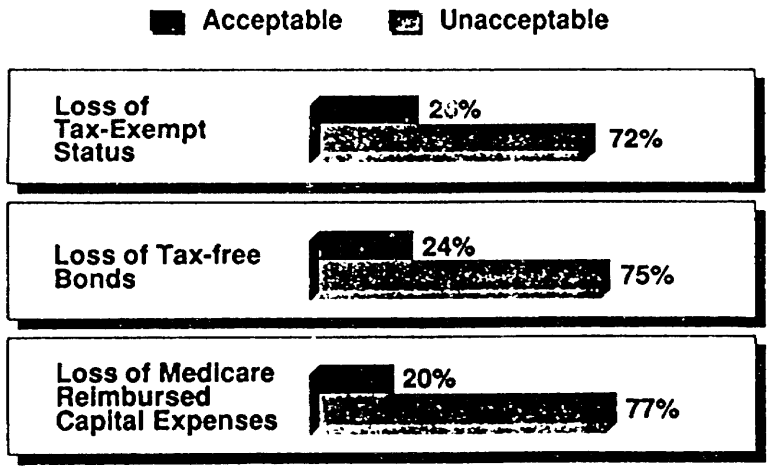
Attachment F

Hospital CEOs Will Accept



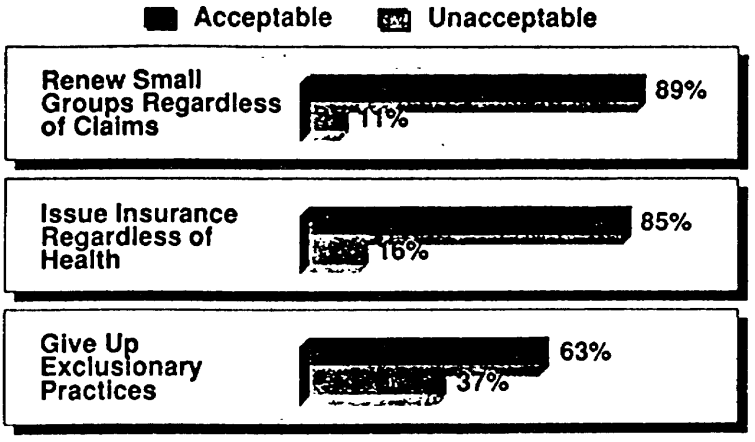
Attachment G

Hospital CEOs Will Not Accept



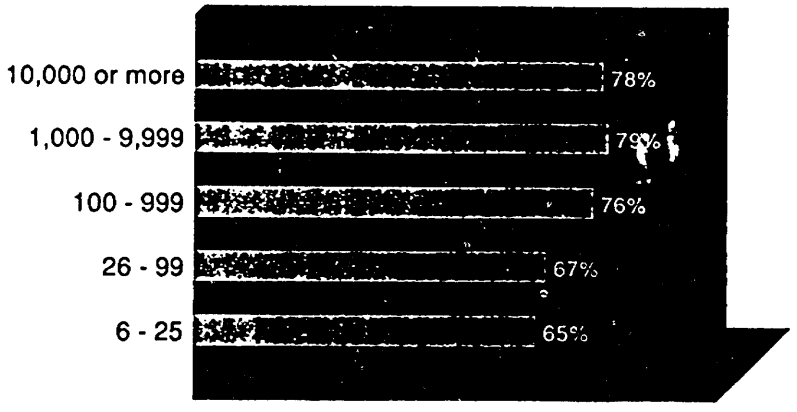
Attachment H

Insurers Will Accept With Reinsurance Mechanism



Attachment I

Corporations Will Accept Mandated Coverage for Full-Timers



Attachment J

PREPARED STATEMENT OF MARK V. PAULY

I want to discuss how a program of market-based health insurance reform can lead to right level and rate of growth in medical spending, as well as providing universal coverage for all. The key to universal coverage, as I and colleagues have argued elsewhere, is to place a mandate on individuals that requires them to obtain at least minimum catastrophic coverage. The uneven impact of such an obligation on low income persons is then offset by closed end refundable tax credits, which are large for low income people and then decline in value as incomes rise.

The tax credits have to be paid for, but there is a way of raising the taxes needed to pay for them that actually improves rather than harms efficiency. The bulk of the cost of a reasonable regimen of tax credits can be covered by making taxable that portion of compensation workers receive in the form of an employer-written check for their health insurance premium. By replacing the current regressive tax exclusion of employer-paid health insurance premiums, with a progressive system of fixed dollar refundable tax credits, we can have a system that is both fair and economical.

Closing this tax loophole will help to make the tax system more equitably, since it is the well-to-do worker who benefits the most from the current tax exclusion. However, there is another, less obvious, but very profound advantage of doing away with this tax break: it will cause the level and rate of growth of health care spending to move to appropriate amounts, and it will do so without requiring either heavy government regulation or a massive public bureaucracy.

To see why limiting of eliminating the tax exclusion is the best way to secure an appropriate rate of growth in medical spending, one needs to understand the form that growth has taken. If the effect of economy-wide price inflation is removed, real national health expenditures per capita have grown at a rate of between 4 and 5 percent per year for decades. A very small part, less than a tenth, of this growth is attributed to changes in the age and gender mix of the population. Half to three quarters of the growth is attributed to what is called changer in technology, or changes in volume and intensity of care. The remaining share of growth is attributed to increases in the prices of inputs into medical services, especially wages of health workers, which increase more rapidly than wages and prices in general.

This generally accepted description of medical cost growth has an important but less generally understood implication: policies to control the rate of growth cannot succeed over the long term unless they address technology or input prices. Policies that address other components of medical cost may do some good, but they cannot solve the problem of cost growth. This logical truism disqualifies many of the proposed remedies for medical cost inflation. Take, just as an example, this year's favorite: using a Canadian-style single payer approach to eliminate the alleged "duplication and waste" that is represented by the administrative cost of private insurers and the complementary billing expenses providers incur. Ignore the fact that much of this administrative cost is not pure waste, but pays for cost-containment services, the provision of information to insurance buyers, and private billing as a substitute for highly distortionary Canadian taxation. Assume that you could cut 10 percent out of total medical care spending by making this massive change. Since health care spending has been giving at about 10 to 12 percent per year, you could have a near zero growth rate next year. But here is the key limitation: *growth would be lowered to that level for only one year;* the effect on the rate of growth would be one time. In the following year, if nothing else is done, new cost-increasing (but beneficial) technology will still be brought on line, nurses' and technicians' wages will rise faster than inflation, and the rate of growth of medical care spending will return to 10 to 12 percent per annum.

The sad fact is that almost all of anyone's favorite nostrums for cutting health care costs—elimination of insurer administrative costs, higher out of pocket payments by consumers, switching doctors from fee for service to salary or greater use of preventative—all have this one shot" property.

Do not misinterpret: these things may still be worth doing if they do more good than harm. But both logic and empirical evidence shows that they will not work to depress the rate of growth permanently. For instance, as William Schwartz has shown, the Medicare prospective payment system did cut hospital cost growth by inducing hospitals to discharge patients earlier. But there is a limit to how much a stay can be shortened, and after about two years of slower growth, there was nothing hospital could do for an encore, and hospital cost growth resumed its normal double-digit trend.

The primary message here is not to be taken in by solemn reassurances for prominent physician or industry experts that they know how to solve the problem of cost growth by eliminating waste, duplication, and unnecessary care. Even if they do

know how—which in my mind is a bet with bad odds—they can only "solve" the problem if they can find more and more fat every year to excise. Sooner or later, (and probably sooner rather than later, though there sorely is some waste in this industry), the only way to cut costs is to stop doing something beneficial.

My proposed remedy proceeds instead from a simple logic. Since the main source of cost growth is technological changes, one wants to choose policies that directly address technical change.

It is, however, obvious that we don not want to stop technical progress cold—but it is equally obvious that if we want to slow down the growth of medical costs, we will have to slow down the rate of spread of cost-increasing technical improvements. If we want what we pay to grow less rapidly every year, we will have to wait for something new, to give up some new innovation, at least for a while, that provides small (but positive) benefit at a substantial cost. It is almost tautological, but still very useful, to say that what we want is a rate of growth that provides us with only the new technology that is worth what it costs, and not the technology that is not worth what it costs. A non-tautological implication of this statement is that a low rate of growth in cost, in and of itself, is not desirable. Instead, we want to slow the rate of growth in medical spending t0 that level at which the value of the medical benefits we have to sacrifice as we cut costs and divert skilled workers and valuable capital away from the medical care sector to other sectors of the economy, is less than the value of the other goods and services those workers and that capital will provide in the other uses to which they will move. We do not desire to cut medical cost growth because it allows us to pile up some kind of national bank account. Nor are cost increases in medical care like cost increases in, say, oil, where cost increases meant transfers to foreigners for receipt of the same number 2 fuel oil. Instead, it is desirable to cut what we spend on medical care when and if we would rather have the smart people who go into medicine, nursing, and biotechnology work instead of providing us with other services, rather than better medical care.

Viewed in this way, it is clear that we should not judge the performance of a country's medical care system to be good just because costs grow less rapidly. It is surely possible for government to control the rate of growth in medical spending, by making it illegal for people to spend more than a certain amount on medical services, even if they want to. But such a strategy is not necessarily best.

What is best, to repeat, is a strategy that comes closest to having medical care system provide us with just as much care as is worth the cost, and no more. I say "comes closest" because special features of medical care as a commodity means that we will never be able to do things perfectly. The uncertainty that patients, physicians, politicians, and researchers all have about the effectiveness of medical care and the indications for its use means that there will necessarily be some waste, especially in hindsight. The risk attached to the incidence of illness leads people rationally to choose insurances, public and private, but those insurances distort behavior and choices of patient and provider, in ways which are to some extent unavoidable. What we can try to do is to provide information on what works and what doesn't, and provide this information not only to physicians, but to insurers and patients as well. Indeed, recent research has strengthened our confidence in the ability of patients to make rational judgments about their own care if they are given proper information in a proper setting, well enough in advance of medical emergencies. It also suggests that patients are nearly as skilled as researchers in judging when they have and have not received high quality of care.

But the most important thing government can do to control cost, I believe, is to stop doing something that makes it impossible for citizens to make the proper tradeoff between benefits and costs, even when they do have good information. The current tax treatment of employer-paid health insurance premiums induces workers to underestimate the true cost of the insurance they buy, and the true value of the medical cost savings they might achieve. If workers receive part of their compensation as health insurance for which the employer writes the check, that component of income is shielded from taxation. In effect, employees can reduce their tax bill by having their employer pay for health insurance rather than pay them cash compensation. Not only is this inequitable, it also makes health insurance appear to be less costly than it really is, because the premium cost is reduced by the amount of the tax savings.

This makes some workers, especially high wage workers who get the biggest tax breaks, choose overly lavish health insurance. It also means that, faced with the choice of a cost saving but less convenient health plan, employees may fail to adopt cost containment devices, because any increased money income made possible by fringe benefit cost savings will be taxed. In effect, our current tax system forces employment-based group insurance purchasers to share any cost savings with the gov-

ernment. A predictable consequence of such a distorted incentive is less enthusiasm for cost containing medical insurance plans.

Removal or limiting of this tax loophole will cause employees, unions, and employers to choose less inflationary health insurance coverage and more aggressively cost containing policies. How much difference removal of the exclusion would make is difficult to say, because this tax distortion dates back to World War II. Research does suggest that insurance purchases are sensitive to the net price of insurance, but estimates of the degree of sensitivity are imprecise, with some studies suggesting high sensitivity and others indicating minimal effects. In any case, such studies can only estimate the initial impact of net price changes, not the effect on the rate of growth in costs or premiums. There have been no studies of the effect of insurance prices on cost containment efforts.

However, the case for removal and replacement of the tax exclusion does not really turn on the estimated size of the impact. Removing the tax exclusion faces all buyers with prices for different health plans that truly reflect their cost. Among other influences, the rate of growth in a health plan's premiums will reflect the form of technology limitation it chooses to adopt. If it is slow to extend coverage to new technology, and manages the use of diffusing technologies, its premiums will rise less rapidly than a plan that covers the latest technology no mater what. But the cost containing plan will also offer less access to up-to-date medical services. If workers and groups of workers choose the plan whose cost is growing more rapidly, it must mean that they judge the benefits of the new technology to be worth the cost. In such a case, a rapid growth in health are costs is a cause for cheer, not concern, since the medical care spending yields more benefit than its cost in terms of other goods and services buyers might have chosen. Conversely, if buyers choose to give up a little quality or convenience in order to save a lot on next year's premiums, that is appropriate too.

If the tax exclusion is eliminated, and reasonably well-informed buyers face premiums properly reflective of cost, then the rate of growth in expenditures that is generated by this market is the right rate of growth, regardless of whether it is high or low. In contrast, a government chosen rate of growth is sure to be wrong for some citizens, since people have different desires as to how much they want to spend on medical services. If the permitted rate of growth is limited to some macroeconomic statistic, like the growth of real GNP, it is by definition arbitrary, and inferior to one informed buyers would choose.

The main message is that appropriate cost containment, as part of health care reform, is best achieved by eliminating tax-based distortions in insurance purchases and replacing that open-ended subsidy with a set of refundable tax credits that do not increase in amount when a person buys a more expensive health care plan. Then we can let vigorous competitive markets with well-informed individual consumers or group purchasers choose the rate of growth of medical spending which is, by definition, close to the right rate.

Government has a role to play in fostering the development of information, and in making transfers to people who cannot afford basic coverage, either because they have low incomes or because they are high risk. The most important thing government can do for cost containment is to stop doing what it is doing now, that is, stop using the tax system to encourage overly costly new technology.

I cannot forecast how much health care cost growth would fall if there was tax reform, although I am sure that there would be some decline, compared to what would otherwise have happened, What I can say is that the size of the decline does not matter, since whatever rate of growth emerges is likely to be close to the appropriate rate. Markets in medical care will never be perfect, but government choice will be even less perfect. As one who does cost effectiveness and cost benefit analysis for a part of my living, I am acutely aware of the serious difficulties and heroic assumptions we experts need to make when we advise public decisionmakers are on choosing the types of new services to be offered and the rate of growth in cost. The alternative, which I much prefer, is to try to get markets to function as well as possible.

Along with two other economists and a lawyer, I have outlined the details of a scheme to use tax credits financed in part by the elimination of the tax exclusion as a way of improving the ability of markets to meet social goals. This approach is called "Responsible National Health Insurance." [1] This approach, I believe, is the best way to achieve appropriate cost containment. Even if our particular proposal

[1] "A Plan for 'Responsible National Health Insurance,'" (with P. Danzon, P. Feldstein and J. Hoff), *Health Affairs*, Vol. 10, No. 1, Spring 1991, pp.5–25.

is not adopted, but private employment-based insurance is permitted to remain, limiting the tax exclusion should be part of any serious health care reform.

RESPONSES OF MR. PAULY TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. I would like to ask a question about expenditure limits. Apart from the obvious consequence that we would hold down spending for health care, what other primary consequences for the health care system would there be were we to adopt system-wide expenditure limits?

What I'm curious about is what will happen if we restrict what providers get for providing services by expenditure limits, but do nothing to control their input costs? Is the rent control analogy an appropriate one here?

Answer. The primary consequence of expenditure limits, aside from the obvious one of holding down total expenditures, would be a reduction in the rate and form of technical change that would be implemented in the medical care system. Previous temporary spending limits have been accommodated by health care providers primarily by reductions in profit margins (when they are positive) and by consumption of existing capital and endowments. This might happen for a while after an expenditure limit, but the eventual, and most important, longer term consequence would be a slowdown in the rate of addition of beneficial but costly new products and services providers could offer. Whether this is a desirable or undesirable consequence depends on the value of the lost new products relative to the cost saved. Arbitrary spending limits (e.g., links to the rate of growth in real GNP) may lead to the elimination of services whose benefits exceed their cost, although the presence of the tax subsidy implies that we currently adopt some beneficial technologies that are not worth their cost. Since we cannot really measure the value citizens place on new technology, there is no reason to believe that spending limits will choose the right tradeoff.

The rent control analogy is not quite appropriate here, since expenditure limits restrict price and quantity, whereas rent controls only limit prices. The consequences of expenditure limits are likely to be similar, however: a reduction in the quantity and quality of services that suppliers are willing to offer.

Question No. 2. In your written statement, you seem to equate volume and intensity of care with technology. What about physician-inspired over-utilization, either because of defensive medicine or reimbursement gaming? Can you distinguish between these things and, isn't it important to do so?

Answer. Some of the changes in technology have probably been caused by physician responses to malpractice laws. We have no definitive estimates of how large this impact is; my own judgment is that it is not large. In contrast, reimbursement gaming does not affect properly measured volume and intensity of care, since reimbursement gaming (if by that one means "upcoding" and the like) only changes price, not real services. Reimbursement gaming could account for part of measured volume and intensity growth, since such growth is usually calculated using price indexes which are not adjusted for gaming. Here again, no one has precise measurement. However, I would not expect gaming to account for much of the long term growth in measured volume and intensity, since that would require that gaming get continuously worse, in a serious way, over decades. I suspect that there have been some episodes of gaming, especially in response to price freezes or reimbursement changes, but I know of no evidence to indicate that providers continuously game the system, to a greater and greater extent. Moreover, the evidence on hospital profits, which shows no long term growth, is not consistent with gaming by them; for physicians it is harder to tell.

RESPONSES OF MR. PAULY TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question No. 1. How would Dr. Enthoven's system of Health Insurance Purchasing Cooperatives (HIPC's) be organized?

Answer. Your questions about Health Insurance Purchasing Cooperatives are better addressed to Professor Enthoven. I personally do not believe that such arrangements need to be mandated by law, though would not object to buyers cooperating as long as they do not develop excessive buyer market power. In any case, these arrangements seem to be designed primarily to push down the prices providers receive for medical services. In my view, however, excessive prices or growing margins of prices over cost are a much less important part of the problem of the growth in medical expenditures than is growing technology. Many managed care plans with relatively small market shares have been able to avoid buying new technology they do not wish to buy (malpractice laws permitting). The rural area served by a single hospital will not be as well served by competing managed care plans, although in many such areas transport of non-emergency patients (who are the great majority

of all patients) to hospitals in other towns is possible. I do not think that an excessive amount of modern, beneficial, but costly technology has been as serious a problem in rural areas as in big cities. The limits on the ability of a single hospital in a small town to offer lower levels of technology to some buyers are largely dictated by the requirements of production and management, not by the market power of the hospital or its unwillingness to be responsive to its customers. To be sure, some hospitals may have a preference for technological "toys," as may their medical staffs, while others may find high tech care more profitable than older style care. Empirical evidence on this subject is confusing, with older studies showing that single-hospital markets had lower cost, while more recent studies show that the rate of growth in costs is higher in markets with fewer hospitals competing. There may therefore be some useful role for buying cooperatives in rural areas, but I see little need for them in non-rural areas of the country.

Question 2. Who would make decisions about limiting the numbers of HIPC's? How would this work in rural areas? Who would decide the membership of HIPC's?

As to your specific questions, my understanding is that Health Insurance Purchasing Cooperatives (HIPCs) would be organized by nonprofit groups responding to Requests for Proposals from state governments, and would be subject to heavy regulation by a National Health Board. If governmental behavior could be relied upon to be wise and efficient, there would be little to fear, but those assumptions do not seem especially plausible. I understand that all persons who purchase insurance individually or as members of small groups would be required to use one of the HIPCs in their area. No HIPC could refuse an applicant based on health status, though it is unclear whether it could reject an applicant on other grounds (e.g., geographic location, type of business). In rural areas, there would probably only be one HIPC. In areas with multiple HIPCs, I gather that "membership" would depend on which HIPC individuals or small groups decided to select, and which applicants the HIPC decided to accept. If there are multiple HIPCs in an area, then they will have to market, and such marketing costs are a large part of the higher costs of small group and individual insurance. I would therefore question the claim that they will achieve economies of scale. If there is only one compulsory HIPC, it can achieve economies of scale, but then one sacrifices both choice and competition.

Question No. 3. How would you avoid adverse selection?

Answer. Your final question about adverse selection raises a more general issue about HIPCs. What are their incentives, and what are their objectives? They play a critical role as a middleman between small group and individual buyers, on the one hand, and Accountable Health Partnerships (health plans) on the other. Requiring them to be nonprofit and subject to votes by those small employers and individuals who have already joined and who choose to vote hardly guarantees either efficiency or accountability. They might have as their objective to maximize membership, since that would probably lead to higher salaries for HIPC executives, but membership maximization alone could lead to preferred risk (not adverse) selection, since additional individuals and small groups would be unlikely to select an HIPC that was negotiating rates for a sicker-than-average population. If explicit risk selection was effectively prevented, then one could have adverse selection in which the HIPC that wants to offer low premiums would choose AHPs whose benefit packages are attractive to healthier people. Presumably the state government would have the responsibility to monitor the HIPCs it approves.

The vision of self-governing non governmental non profit enterprises behaving in the best interests of their members is an appealing one, but is unrealistic in a world in which not all members want the same objectives, and all members have little time and incentive to monitor their HIPC. They would work as well or as poorly as the United Way, labor unions, or professional organizations. Would they advance the wellbeing of their members, would they avoid selfish behavior in the interest of those members, and would they function efficiently? Such organizations are often necessary but rarely perfect. I am not persuaded that HIPCs are necessary, that there needs to be another layer of organization (and bureaucracy) between the buyers of health insurance and the health plans they buy. Having to pay somewhat higher administrative costs for health insurance is something that small groups and individuals cannot avoid, and creating this extra layer in itself does little to change the causes of those high costs. Those buyers who want to work with purchasing organizations, such as Chambers of Commerce, already can do so.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

I would like to thank and commend our distinguished Chairman, Senator Lloyd Bentsen, for calling us together to begin to solve one of the greatest domestic challenges facing our Nation today—our national health care crisis.

There are plenty of statistics that illustrate how our health care system is in dire need of repair. We've heard these numbers over and over again—the astonishing number of hard working Americans who have no insurance; the spiraling cost of doctors' and hospital bills; the ridiculous, unacceptable prices of prescription drugs.

We know these figures all too well, and it is not necessary to repeat them now. We know the problem. And we all know the message—you better not get sick if you live in America. And what an appalling message that is.

Mr. Chairman, as you know, I continue to be concerned that we are not listening to the message the American public is giving to us about health care costs, and prescription drug costs in particular. According to a Kaiser poll that will be summarized for us today, a full 73 percent of Americans—and 69 percent of those identifying themselves as Republicans—believe prescription drugs should be subjected to price controls. In short, the American public is far ahead of me in advocating the use of strong efforts to contain these out-of-control costs.

Our constituents are now calling for action. They have said to us in town meetings, in letters and in phone calls, "We are tired of talk. It's time to see some results."

As an institution, we in Congress must come together and devise a plan—a strategy—that will work for all Americans. And this plan MUST get to the heart of the health care crisis—controlling health care costs and guaranteeing access to our health care system.

Our distinguished Chairman has demonstrated his commitment to working toward this goal, and I look forward to contributing to this process. But I must say that any solution to this monumental problem can result if, and only if, we have the support of our President. Our country needs—and is now demanding—that the President make health care reform a national priority—its number one priority.

Frankly, it has been quite a disappointment that, with all this talk, the Administration has yet to provide to us legislation that reflects the President's health care proposals. In so doing, the Administration has failed to respond to Majority Leader Mitchell's challenge to deliver a plan of action by the start of this series of health care reform hearings.

The very little that President Bush has revealed of his plan appears far from adequate. In fact, a recently released report by the respected Employee Benefits Research Institute (EBRI) concludes that the President's health care experts significantly underestimated the cost of his plan and overstated the number of people who would be covered under it.

Despite my disappointment with the President and his plan, I do welcome him—and encourage him to further his commitment—to this debate. Our constituents back home are tired of partisan bickering. Frankly, I do not blame them. They do not want a Republican plan or a Democrat plan; they simply want a plan that finally responds to and relieves their fears.

Simply put, our constituents are tired of living in fear that they may lose, or no longer be able to afford, their health care insurance—the one protection they have to avoid financial disaster. We must make every effort to eliminate this fear that too many Americans must live with every day of their lives. It is time to get down to business.

PREPARED STATEMENT OF ROBERT D. REISCHAUER

Mr. Chairman, I appreciate the opportunity to appear before this Committee. My testimony today will cover proposals for comprehensive health care reform, their potential to expand access to insurance coverage and control health care costs, and the Congressional Budget Office's (CBO's) methods for assessing the cost containment provisions in health legislation.

INSURANCE COVERAGE UNDER THE CURRENT SYSTEM

In March 1990, an estimated 33.4 million people—or 13.6 percent of the population—were without health insurance coverage. During the next year, the number of uninsured people grew by 1.3 million. About three out of five uninsured people are poor or near-poor, with incomes of less than 200 percent of the poverty threshold.

Moreover, estimates for 1987 indicate that the number who were uninsured at some time during that year was about 30 percent higher than the number who were uninsured during the first quarter of the year. If the same was true today, then about one in six people would have been uninsured at some time during the year.

The problem of inadequate insurance coverage is exacerbated by our inability to slow the growth in the cost of health care. Cost increases are raising premiums for health insurance faster than the growth in wages and national income, thereby further eroding coverage. Since 1980, the proportion of the population under 65 without health insurance has increased by more than one-fourth. Moreover, there is considerable evidence that those who are uninsured use less health care and have worse outcomes when they do use the health care system.

APPROACHES TO ACHIEVING GREATER INSURANCE COVERAGE

Because of concern about the dual problem of the rising number of people without insurance and the increasing cost of health care, a substantial number of bills have been introduced that are intended to expand access and control spending. These proposals reflect a diverse set of approaches. Those, however, that could be characterized as comprehensive health care reform—in other words, changing the health care system to ensure that virtually everyone in the nation would have access to health insurance—can be grouped into three general approaches:

- Proposals that would offer tax subsidies to enable those who are uninsured to purchase private health insurance, combined with additional regulation of the health insurance market to ensure that insurance would be available and more affordable.
- Proposals that would require employers to offer health insurance to their employees or to pay a tax ("play or pay"). The tax revenues would be used to offset some of the cost of a public insurance plan. Additional tax revenues would be needed, however, to finance the shortfall for workers whose employers chose to "pay" and to subsidize coverage for low-income people without jobs who were not covered by Medicaid or Medicare. This approach would also involve additional regulation of the health insurance market to ensure that insurance policies would be available to employers who wanted to "play."
- Proposals that would replace the existing health care system with a single-payer public health plan covering everyone.

Any of these three general approaches would significantly expand access to health insurance. The third approach would, by definition, provide everyone with insurance. Continuity of health insurance coverage would also be improved under each of these alternatives. The approaches differ, though, in their potential impacts on national health spending, federal expenditures for health, the extent to which control over health care spending would be improved, and the ability of consumers to choose their own health insurance coverage.

The impact of any health proposal on access, spending for health, and on the federal government's costs would depend on the details of the proposal. Such details would include the particular package of health benefits—namely, the services that would be covered as well as the deductible amounts and coinsurance payments that would be required—plus those provisions intended to contain costs, such as managed care and methods for setting reimbursement rates. The effects would also depend on many other details of the particular proposal under consideration. For example, if a tax subsidy were used, the effects would vary depending on tax rates, definitions of income, and configurations of filing units, as well as any complementary changes made in regulating the insurance market for small groups. Under a "play-or-pay" plan, those outcomes would be affected by such factors as the contribution rate required of employers and employees to participate in the public plan, the treatment of part-time workers, and new regulations of the small group insurance market. The effects of a single-payer public system would vary significantly depending on the extent to which private insurance was permitted to supplement the public plan and on the choice of administrative mechanisms used to operate the plan.

An overview of the effects of each approach, as illustrated by a specific proposal, is presented in Table 1. In each case, the estimated effects on national health expenditures in Table 1 take into account increases in spending resulting from new insurance coverage. Offsetting reductions in administrative costs and payment rates that would occur under a single-payer system are included only in that case. A detailed description of the characteristics of each of the illustrative proposals examined here is contained in the appendix.

Effects on federal expenditures for health are presented in terms of both federal outlays for health and tax expenditures related to the exclusion of health insurance

from taxable income and other deductions for health care. The estimates of tax expenditures reflect the impact those proposals would have on both income and payroll tax revenues. If federal outlays for health increased because of expanded insurance coverage through a public plan, and tax expenditures decreased because few people would continue to have employment-based insurance, then the increase in federal outlays would be offset in part by an increase in tax revenues. Conversely, an approach that expanded both employment-based coverage and public coverage would raise outlays and tax expenditures. Those estimates assume that the federal government would incur all of the increase in outlays for an expanded public plan. Those costs could, however, be shared between the federal and state governments. If that were the case, then the effect on total federal health expenditures would be less than that shown in Table 1.

Table 1.—COMPARISON OF ESTIMATED EFFECTS OF ILLUSTRATIVE WAYS TO INCREASE INSURANCE COVERAGE

[In percent]

	Tax subsidies and market reforms[1]	"Play or Pay employer mandate and market reforms[2]	Single-payer public plan[3]
Insurance Coverage			
Access	Improved	Improved	Assured
Percent Insured	93 to 95	97 to 99	100
Continuity	Improved	Improved	Assured
Initial Percentage Change in Spending for Health[4]			
Nationwide	2	3	Near 0
Federal Government Outlays	8[5]	17[6]	75[7]
Tax expenditures[8]	39	9	–95
Total Health Expenditures	15	15[6]	34[7]
Other Effects			
Potential for cost control	Improved only if other policies are adopted	Improved only if other policies are adopted	Improved
Choice of Coverage	Unchanged, or reduced if cost controls are adopted	Unchanged, or reduced if cost controls are adopted	Essentially eliminated

[1] Assumes tax credits equal to full value of insurance would be provided to half the uninsured and that new coverage would result for all members of this group. Some additional coverage would result from partial tax subsidies or from market reforms.

[2] Assumes no change in overall or full-time employment would occur. Also assumes that all those eligible for free insurance under the public program would enroll but that only some among other eligible groups would enroll.

[3] Assumes the single payer would use Medicare's rates, with hospital rates increased to cover costs. Spending would fall slightly if a relatively low increase in use occurred among the currently uninsured and if potential savings on administration were fully realized. Otherwise, spending would increase slightly.

[4] Percentage changes are relative to current spending for health in each category shown-nationwide, federal outlays, federal tax expenditures, or total federal expenditures. Effects of financing provisions are not shown, nor are effects on individuals, firms, or state and local governments.

[5] Represents the portion of the tax subsidy that is a refundable credit.

[6] Includes the total cost of the public plan. More than 70 percent of the cost for employees in the public plan would be offset by tax collections from employers and employees.

[7] Assumes federal government would pay all costs of the public plan, although costs could be divided between federal, state, and local governments in a variety of ways.

[8] Includes effects on payroll taxes, although those are not usually counted as tax expenditures.

NOTES: Currently, about 86 percent of the population is insured. All three alternatives assume insurance plans typical of those available currently, with substantial copayment requirements and no coverage for long-term care. see appendix for full description of the alternatives.

SOURCE: Congressional Budget Office.

Tax Subsidies, Combined with Additional Regulation of the Insurance Market

Under current law, the federal tax code provides a substantial subsidy for employment-based health insurance—nearly $60 billion in 1990, when the effect on both income tax and payroll tax revenues is considered. That subsidy arises from excluding qualified employer-paid health insurance premiums and certain other health costs from workers' incomes for tax purposes. In addition, low-income workers are eligible for a refundable tax credit on the purchase of health insurance that covers their children. This credit is for all premium costs, subject to a ceiling equal to 6 percent of qualified earnings. The maximum credit is now $451.

The current system of tax subsidies could be expanded to make the purchase of private health insurance less expensive for those who do not receive employment-based insurance. The President's Comprehensive Health Reform Program, for example, would offer a direct tax credit for the costs of a health insurance policy worth up to $3,750 to low-income people, depending on household size and income. Individuals with incomes up to $50,000 and families with incomes up to $80,000 (depending on tax filing status) would be offered either a tax credit or a tax deduction for health insurance.

For such a system of tax subsidies to be effective, however, it would have to be combined with additional regulation of the insurance market to ensure that health insurance policies would be available and more affordable. The President's plan includes a variety of changes that would ensure that all groups could obtain health insurance, guarantee renewal of existing policies, and prohibit exclusions for preexisting conditions.

CBO's preliminary analysis of the President's plan indicates that offering a $3,750 tax credit to all people with incomes below the specified limits would reduce the number without insurance by about 50 percent.[1] In addition, the smaller subsidies and tax deductions for higher-income people, as well as the proposed changes in the health insurance market, would expand coverage somewhat. We cannot, however, precisely assess the extent of that additional insurance. Although health insurance would be available and more affordable as a result of the insurance market proposals, it is uncertain how many of the uninsured with low or moderate incomes would choose to purchase insurance in response to the limited subsidy. For example, an uninsured head of household with one dependent and an income of $25,000 who purchased a policy for $2,500 would have the choice of a $250 tax credit or a tax deduction of up to $2,500 for health insurance premiums. At an effective marginal tax rate of 15 percent, this family would receive a greater subsidy—$375—by choosing the tax deduction but would still have to pay the remaining $2,125 of the annual premium.

Although it would not guarantee that everyone in the United States would have health insurance, the tax subsidy approach (combined with changes in the health insurance market) would improve access to health insurance. Further, the changes in the health insurance market would ensure continuity of health insurance coverage for those who wanted to change jobs.

The effect of this proposal on national health expenditures would depend on how much new insurance coverage would result, since the newly insured would use more health services than they had previously. If the percentage of people with insurance increased from 86 percent to 94 percent of the population, national health expenditures could rise by about 2 percent. In addition to the uninsured, a substantial number of currently insured people could be eligible to receive some subsidy under this approach, but their use of health services would not change much.

The effect on federal expenditures for health (both outlays and through tax expenditures) would depend on the number of people with new insurance and on those who had previously bought insurance that would entitle them to receive a subsidy. Providing the full refundable tax credit to half of the uninsured population would increase federal outlays about 8 percent. This estimate, however, does not take into account partial tax credits that would be provided to other people. Because of the partial tax subsidies available to many of those who already have insurance, federal tax expenditures would rise by 39 percent. The net effect would be a 15 percent increase in total federal expenditures for health. The impact of this increase in federal expenditures on households and businesses would depend on the specific financing methods used to increase revenues to cover these costs, which are not specified in the illustrative proposal.

A "Play-or-Pay" Employer Mandate, Assured Access to a Public Plan, and Additional Regulation of the Insurance Market

Another comprehensive approach would be to mandate that all employers either provide health insurance to their workers or pay a tax that would be used to help finance a public insurance program for people who were not covered. Employees would also be mandated to accept the offered coverage. Under this approach, additional regulation of the private insurance market would also be necessary in order to ensure that all employers had access to affordable private health insurance policies, regardless of the health status of their work force.

---

[1] For a more complete discussion of CBO's analysis of the President's Comprehensive Health Reform Program, see Robert D. Reischauer's testimony of March 4, 1992, before the Committee on Ways and Means.

Even though rates for group health insurance are generally substantially lower than rates charged to individual applicants, some employers do not offer insurance because their work force is primarily low-wage and their total compensation package could not easily be adjusted to accommodate the cost of health insurance. Other employers now face prohibitively high insurance premiums because of previously existing health conditions of some of their employees. Even with additional regulation of the insurance market, both types of firms would face significant costs under a mandate that they might not be able to transfer to workers in the short run.

To reduce or eliminate the resulting adverse effects—more part-time employment for low-wage workers or even bankruptcy of some small firms—the "play-or-pay" version would permit employers to choose between providing insurance directly or paying a payroll tax that would partially fund a public program. Uninsured people, whether or not they were employed, would then have the option to be insured under the public plan. Because additional regulation of the insurance market would limit the allowed variation in premium levels charged to firms with different compositions of employees, some employers who do not now offer insurance to their employees would choose to "play" rather than "pay" the tax.

An illustrative employer mandate with a play-or-pay option could, for example, include a requirement that all employers provide insurance to their full-time (25 or more hours per week) workers or pay a payroll tax of 7.5 percent of payroll, with the employee contributing an additional 2.5 percent of wages.[2] Regulation of the insurance market could prohibit insurers from varying premiums charged to small groups based on group-specific risk, thereby ensuring that no group would face prohibitively high insurance premiums.

Under this illustrative option, coverage through the public plan would also be available to individuals and families who are not attached to the work force. Individuals and families with incomes below the poverty level would be offered coverage through the public plan at no cost to them. Individuals and families with incomes above the poverty level would have to contribute to the cost based on a sliding scale that would reach the full cost for those with incomes at or above 300 percent of poverty. Individuals and families with incomes above 300 percent of poverty would have to pay the full cost of health insurance coverage.

Under this plan, access to health insurance would be significantly improved-approximately 23 million of the 33 million people without health insurance in 1990 would gain coverage through the workplace. Of these 23 million, about 10 million would have employment-based health insurance and 13 million would receive coverage through the public plan. The remaining people without insurance would not be included in the mandate, but they could choose to participate in the public plan by paying the required premium themselves.

With most of the population covered by health insurance, national health expenditures would rise by at least 3 percent, reflecting the increased use of health services by this group. Federal expenditures for health would also rise for two reasons. First, more employment-based health insurance would increase the related tax expenditure. Second, the payroll tax imposed on firms that did not offer health insurance would not be sufficient to cover the costs of a public plan since, on average, these firms employ a lower-wage mix of workers. As a result, the public plan would require additional subsidies from general tax revenues. The effect of this increase in general tax revenues on households and businesses would depend on the specific financing mechanisms used. CBO estimates that, for the illustrative plan described above, total federal expenditures for health care would rise by 15 percent, taking into account the increases in both outlays and tax expenditures.

A Government-Run, Single-Payer System

Establishing a government-run, single-payer system would be another approach to comprehensive health care reform. Although the two previous alternatives would build on the existing multiple-payer system, thereby maintaining both private and public components, a single-payer public system would involve a complete restructuring of the current system for financing and delivering health care.

In the example discussed here, a new public insurance plan covering all legal residents would replace existing insurance for acute-care services.[3] The benefit package would be actuarially equivalent to the average benefits currently provided under private plans and Medicare. Medicare's current payment methods for hospitals and physician services would be extended to everyone in the public plan, though the ac-

[2] For a discussion of an employer mandate without a player-pay option, see Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage* (July 1991).

[3] For a more complete discussion of the single-payer approach, see Congressional Budget Office, *Universal Health Insurance Coverage Using Medicare's Payment Rates* (December 1991).

tual rates might be adjusted to assure that the costs to providers would be covered. The program would be financed by broad-based federal and state taxes. Private health insurance would be permitted to offer coverage only for services not included in the public plan. Medicaid would continue to pay the required copayments under the public plan for low-income people and would provide coverage for long-term care services as it does now.

Under this plan, estimates for the initial change in national health spending would be near zero, as the result of several offsetting factors. Spending for acute-care health services would increase (at least before cost controls were put in place). The increase would take place because comprehensive insurance coverage and higher payment rates for some services previously paid by Medicaid and Medicare would be only partly offset by lower payment rates for services previously paid by private insurers. Additionally, administrative costs would fall because many payers in the current system would be replaced with a single payer.

Federal outlays would increase initially by 76 percent under this illustrative plan because most spending for acute-care services would be transferred to the public sector. These higher outlays could be assumed by the federal government alone, or could be shared among federal, state, and local governments. Private spending on insurance and health care would fall by about the same amount. The current tax subsidy to employment-based insurance would be eliminated under this approach and, consequently, tax expenditures related to health care would decrease by around 95 percent. Revenues to finance the increase in federal expenditures for health would, of course, increase taxes for households and businesses, and the effects of this increase would depend on the specific financing mechanisms used. The net effect on federal expenditures for health would be an increase of 34 percent.

POTENTIAL TO CONTROL HEALTH SPENDING

The preceding analysis of alternative approaches to achieving comprehensive health insurance coverage assumed that cost controls were not included, with the exception of using Medicare's payment methodologies under the single-payer public plan. But effective cost containment could be incorporated into each of these approaches, thereby holding national and federal expenditures for health care below the levels indicated above. Control of health care costs would, however, imply changes from the current health care system that would affect the way in which health care was obtained because coordinated policies that combined uniform prices for all providers, controls over use of services, regulation of capital decisions and of the adoption and dissemination of new technology, and appropriate incentives for consumers would be required. As a result, some limitations would almost certainly have to be imposed on consumers' choices of health insurance coverage, providers, and alternative treatments. In addition, the development of new technologies would probably slow and waiting times to use them would probably lengthen.

Effective control over health care costs could be achieved most directly under a government-run, single-payer health care plan. This approach would require the most government involvement, with financing running through government budgets. As a result, it would put direct responsibility on the single financing authority—the government—for making decisions that would largely determine total and government levels of health expenditures. In addition, there would almost assuredly be some reduction in health care spending Under a single-payer system because of substantially lower administrative costs.

A single-payer system would not, however, guarantee effective control of health care expenditures. The extent to which spending was constrained would depend entirely on the decisions that were made about prices, use of services, cost-sharing by patients, and the amount and distribution of capital and technology.

Health care costs could also be controlled under other systems—including the existing multiple-payer, public/private one. Coordinated policies that applied to all payers, providers, and consumers could be put in place now or concurrently with a move to offer tax subsidies or with implementation of a play-or-pay mandate on employers to expand insurance coverage. In all three cases, national and federal health expenditures could be constrained to lower rates of growth than would occur otherwise.

Creating market incentives to increase the efficiency of the system has also been discussed, most frequently in the context of using tax subsidies to expand access to health insurance. This approach has been presented as an alternative to the highly regulated one that would be implied either by a single-payer public plan or by government imposition of uniform policies encompassing prices, controls on use, and regulation of other aspects of the health market. The market approach to controlling costs would create incentives for consumers and other payers to choose insurance

packages and providers that offered the most efficient and least expensive options for treatment.

There is great uncertainty about how effective a market incentive approach to controlling costs would be, either in the short run or in the long run. It would, however, offer the advantage that consumers and providers would probably retain more choice of insurance coverage and options for treatment than under the other approaches to control costs.

ESTIMATING THE EFFECTS OF COST CONTROL PROVISIONS ON NATIONAL EXPENDITURES FOR HEALTH

Over the past two decades, both public and private payers have made concerted efforts to apply many cost control strategies to the current health care system. As a result, there is evidence on the potential of at least some types of cost containment approaches to affect health care spending.

The Committee has asked me to discuss how successful various types of cost containment provisions are likely to be in restraining the growth in health care expenditures. To give you an understanding of CBO's estimating methods, let me describe several options for controlling health care costs and the issues that these options raise for cost estimating. Where possible, I will also indicate the magnitude of the potential reduction in national health care expenditures that might be estimated for each proposal.

This discussion is intended to be illustrative only, since the specific legislative language would have a considerable effect on the estimated savings. For CBO to include savings in its cost estimates, as a general rule the options must be specific and require explicit actions, rather than rely solely on encouraging voluntary efforts by the private sector. Also, estimates of proposals that would dramatically restructure the health care system are considerably more uncertain than estimates of policies that would require only modest adjustments to current arrangements. We usually find it much easier to estimate the budgetary effects of legislation that would change provisions of Medicare—a centrally controlled program with a single payer and a defined population—than to estimate the impact of legislation designed to lower the level or rate of growth of national health spending. In either case, our ability to analyze the impacts of legislation on health spending is greater the more specific the cost containment provisions are.

Increased Cost Sharing for Health Services

Strategies that would raise the out-of-pocket costs of health care for consumers are predicated on the assumption that consumers would become more cost-conscious if they paid more. In other words, they would be more likely to consider whether the value of an additional visit to the doctor was worth the extra cost or would seek out providers who were more economical or charged less.

Cost sharing for health services could be increased in a number of ways. One could mandate minimum cost-sharing requirements for private insurance, eliminate dual insurance coverage that offsets cost-sharing requirements of individual policies, or prohibit the use of flexible spending accounts to pay deductible amounts and coinsurance requirements. For example, if mandated cost sharing had been set at a level that increased out-of-pocket costs for the population with private indemnity health insurance from 25 percent to 35 percent in 1990, then national health expenditures would have been about 1 percent to 3 percent lower. This effect would be relatively small because consumers are not particularly sensitive to changes in their out-of-pocket costs. The reason is, in part, that they lack knowledge about alternative treatments, their costs, and their efficacy, and, therefore, they delegate decisionmaking to physicians and other providers.

Expanded Controls on the Use of Services

Managed care and controls on use can reduce inappropriate or unnecessary health care. Overall, however, the evidence of their effectiveness in reducing costs—other than through fully integrated HMOs with their own delivery systems suggests that substantial savings could not be achieved by extending them to more people. Some reduction could occur, however, if expanded controls on the use of services were concentrated on populations with above-average hospital use.

One legislative approach might be to provide federal financial incentives to expand enrollment in HMOs. Incentives, however, would not necessarily elicit the desired increase in voluntary enrollment in HMOs unless they were very large. Further, because only some types of HMOs are effective at reducing use and expenditures, only a portion of any new enrollees would actually use fewer services. Finally, the federal costs of the financial incentives to expand enrollment in HMOs would offset some or all of the savings.

Price Controls

Price controls could be effective in reducing both the level and the rate of growth of spending, but their impact would be partially offset because providers would increase the volume of services (or change billing practices) to recover lost revenues. In addition, price controls applied to only one segment of the market would generally result in higher spending in other segments of the market.

For example, if the prices of physicians' services under the Medicare program were reduced 10 percent, CBO estimates that Medicare's spending for these services would be reduced 5 percent. This estimate reflects our assumption that physicians would offset about half of their potential revenue loss through increased Medicare volume. If providers attempted to keep their overall revenues constant, spending on physicians' services by the non-Medicare population could also rise. As a result, although Medicare's spending for physicians' services would declines percent, that reduction might not significantly affect the level of national health spending.

Medicare's share of the health care market is sufficiently large that it could unilaterally set prices that are somewhat below private payers) prices, without affecting access to care for most Medicare beneficiaries. Access to care by Medicaid beneficiaries, however, has been adversely affected by the much lower prices that providers are offered in some states for serving this population. In the private market, most insurers do not have sufficient market power to prevent providers from billing the patient for the balance if they limit prices. Thus, under competitive conditions, a private insurance company that limited its payments could lose some of its market share to insurers that paid higher prices and thereby reduced patients' out-of-pocket liability.

Alternatively, government regulation could set maximum prices for physicians' services that all payers had to follow. In other words, insurers would not be allowed to pay more, and physicians would not be allowed to bill patients for amounts above the regulated prices. Under such an all-payer system, providers could increase volume to offset some, but probably not all, of their lost revenue. Administrative costs would decline somewhat, since providers would not have to maintain and monitor many separate price schedules and claim forms. In addition, the authority that determined prices would also control their rate of increase. If the legislation included rules that would limit the growth in prices to less than the projected rate, then price controls in an all-payer system would generate lower national health expenditures than would otherwise occur.

For example, if the annual rate of growth in health care prices could be reduced by as much as 2 percentage points as a result of price regulation under an all-payer system, growth in national health expenditures would be cut by at least 1 percentage point a year. (This assumes that half the potential drop in spending that stemmed from the slowing of price increases would be offset by growth in the volume of services provided.) Over a five-year period under such a scenario, spending for health would be 4 percent to 5 percent less than it would otherwise have been.

Price controls carried out through a single-payer system could reduce reimbursements by the same amount and could also sharply cut administrative costs for insurers and providers. In fact, the one-time drop in the cost of administration could have been around $22 billion in 1990, under the conservative assumption that only the administrative costs related to billing of claims would be reduced if a single-payer system had been fully in place that year. National health expenditures would, however, have fallen by this amount only if prices paid to providers had been reduced to reflect the lower administrative costs that they would have incurred. Legislation including both price controls and provisions for uniform monitoring of providers' patterns of care would have an even greater impact than price controls alone, since monitoring would reduce the magnitude of the response in volume.

Limits on the Tax Exclusion for Employer-Paid Health Insurance Premiums

Limiting the tax exclusion for employer-paid health insurance coverage could reduce health spending by inducing employers and employees to change the provisions of their insurance policies. If the new policies incorporated higher cost-sharing by consumers, for example, the number of services used would fall. One way to limit the exclusion would be to include in an employee's taxable income any contributions by employers (including those in cafeteria plans and flexible spending accounts) that exceeded a certain level. For example, if employers' contributions that exceeded $250 a month for family coverage ($100 for individual coverage) had been treated as taxable income in 1990, about half of all insurance plans would have been affected and the federal tax subsidy to employment-based insurance would have been reduced by about $11 billion.

If such limits were enacted, workers who currently have high levels of coverage would have two choices. They could continue their current coverage and pay federal

income and payroll taxes on the excess coverage. Alternatively, they could negotiate with their employers to cut back some, or all, of the excess coverage in exchange for higher wages, thereby also raising their taxable incomes. (Employers would be indifferent between continuing current health benefits or substituting higher wages for them because both are tax-deductible business expenses.)

Lower amounts of coverage could be accomplished in several ways that would also help to reduce the growth in health care costs. First, traditional insurance could be replaced with HMOs and other effective managed care options. Second, higher copayments could be used to lower the cost of coverage. Third, coverage for some benefits (for example, chiropractic and dental care) might be dropped or scaled back. Finally, reimbursement to providers could be reduced, although this possibility would either limit the insured consumers' choice of providers or increase their out-of-pocket costs. In fact, all these ways of cutting back coverage would represent major departures from health insurance coverage as we know it today. Most people with employment-based insurance now have limited cost sharing and relatively unrestricted choice of providers, features that have been popular for decades. If workers chose to maintain their existing coverage, national health expenditures would not be affected much.

Limits on Expenditures

Legislation that provided for prospective budgets for hospitals, expenditure targets for physicians, and caps on overall national spending would involve major changes in the existing U.S. health care system, but it could result in substantial reductions in the rate of increase in health spending. The legislation would, however, have to include specific details of the mechanisms for setting, updating, and enforcing the limits.

For example, suppose legislation was passed that established prospective budgets for hospitals, with specific formulas for setting and updating them, and there was no leeway to increase the budget for a hospital when overruns occurred. In that case, one could estimate the impact on national health spending as the difference between total spending under the budgets and projected total spending for hospital services in the nation without the legislation. Similarly, if legislation included provisions for setting caps on expenditures for various segments of the health care sector and specified the formulas to determine the annual rate of increase in the caps, then one could estimate the savings by comparing the caps with projected spending in their absence.

To illustrate the effect of an expenditure cap on national health spending, assume that legislation had been put in place beginning in 1985 that included a cap that constrained the increase in total health spending to the rate of population growth (1 percent a year) plus 2 percentage points above the rate of general inflation. If enforced, national health spending would have been only $589 billion in 1990, or about 12 percent lower than the approximately $666 billion that was actually spent that year.

If, however, limits on expenditures were applied selectively to some groups and not others, then providers could increase prices and the volume of services for other groups in order to maintain revenues, without incurring penalties for exceeding the limits for the covered population. Although savings to the segment of the market subject to the limits on expenditures would exist, national health spending might not fall much.

Summary of Cost Control Assumptions

When considering various approaches to cost containment, one needs to keep several factors in mind:

- Providers can increase volume in order to recover revenues lost because of restrictions on price, regardless of whether the price controls are imposed on all or part of the system.
- Providers can increase prices in order to recover revenues lost because of more stringent monitoring of use, regardless of whether the monitoring is imposed on all or part of the system.
- Policies that affect only one segment of the market may be effective in reducing spending for that segment but still not lower overall spending much. Policies that extend to all consumers, payers, and providers generally produce a greater impact on national health spending.
- Proposals that encourage, rather than require, changes in the behavior of providers, insurers, or consumers, and that do not include strong incentives or penalties, have little effect.

As a result, some policies have the potential to achieve greater control over health care costs than others. Examples are uniform pricing under either an all-payer or a single-payer system, reviewing the treatment practices of physicians, and enforcing limits on expenditures. If put in place concurrently, these policies could noticeably slow the rate of growth in health spending.

CONCLUSIONS

Each of the three approaches to expanding health insurance coverage could significantly reduce the number of uninsured people in this country, and would assure that everyone below the poverty level would have financial access to insurance. In addition, each approach could be combined with effective controls over health care costs. While cost containment could be accomplished most directly through a single-payer public plan, the same outcome would be possible under either a tax subsidy approach or a play-or-pay employer mandate.

Control over costs, however, would probably require extensive government involvement in the private health care market to ensure that there would be uniform policies covering prices and quantities of services, capital investment, and adoption of new technologies. Moreover, these uniform policies would adversely affect some aspects of the current system that many people view as desirable. In particular, consumers would probably face increased constraints on their freedom to choose providers, health insurance coverage, and alternative treatments. They might also face greater delays in obtaining treatment, and technological progress in health care would probably occur more slowly. The magnitude of these changes would vary directly with the stringency of the controls on costs.

APPENDIX.—DESCRIPTION OF ILLUSTRATIVE PLANS

This appendix describes in more detail the assumptions made about the three illustrative plans that are compared in Table 1 of the testimony. For all three plans, the insurance benefit package was assumed to cover only acute-care services, not long-term care. Further, substantial copayment requirements would be imposed on patients under these plans.

TAX SUBSIDIES AND MARKET REFORMS

The analysis of the tax subsidies and health insurance market reform approach to comprehensive health care reform draws from the Congressional Budget Office's (CBO's) March 4, 1992, testimony before the Committee on Ways and Means of the House of Representatives on the effects of the President's Comprehensive Health Reform Program on access to health insurance. The President's plan has four basic features that would expand access to health insurance:

- Tax units with income below the tax entry level—that is, the income below which a family would owe no taxes—would be eligible for a full refundable tax credit of $1,250 for an individual, $2,500 for a two-person family, and $3,750 for a family with three or more members. In 1992, tax entry levels are $5,900 for an individual, $9,850 for a head of household with one dependent, and $15,200 for a married couple with two children. The tax credit would be in the form of a voucher that could be used by low-income families to purchase health insurance.
- The maximum tax credit would phase down to 10 percent of the full credit for tax units between the tax entry point and 150 percent of the tax entry point.
- Individuals with incomes up to $50,000 and families with incomes up to $80,000 (depending on tax filing status) would be offered either a tax credit of 10 percent or a tax deduction for health insurance.
- Health insurance premiums for the self-employed would be fully deductible, up from the current 25 percent deductibility.

To assure that health insurance would be available and more affordable to those who wanted to purchase it, the President's plan also includes requirements on states and new regulation of the health insurance market:

- States would be required to work with health insurers to develop basic health insurance benefit packages that would cost the amounts of the tax credits.
- States would be prohibited from requiring health insurers to include specified benefits or coverage provisions.
- Health insurance networks would be established to enable small businesses to obtain insurance with lower administrative costs than are currently incurred.
- Health insurers would be required to insure all groups that wanted to buy health insurance. Coverage would be guaranteed and renewable. Preexisting

condition clauses that limit coverage under employment-based policies would generally be prohibited.
- Limits would be placed on the ability of insurers to set premiums based on variations in risk among similar blocks of business, and mechanisms to spread risks across insurers would be developed.

"PLAY-OR-PAY" EMPLOYER MANDATE AND MARKET REFORMS

Under this illustrative option, all employers including the government would have the following choice:

- Either offer at least a minimum insurance plan to employees who worked 25 hours or more per week; or
- Pay a payroll tax of 10 percent of payroll—7.5 percent assessed on the employer and 2.5 percent assessed on the employee.

Nonworking spouses would have to be covered by the plan. Dependents, other than spouses, would have to be covered through age 18 (age 23 for full-time students). Children might be covered by either spouse's plan at the employees' discretion, but would have to be covered by at least one of them.

Employers would have to provide benefits that were actuarially equivalent to a minimum plan: a single annual deductible of $250 per person, a coinsurance rate of 20 percent, and a catastrophic limit of $875. The premium for family coverage under such a plan is estimated to be about $2,645 in 1990. (Roughly 90 percent of workers have coverage that is at least this generous.) To be excused from the payroll tax, the employer would have to contribute 75 percent of the cost of this minimum plan.

Employers who chose to pay the tax rather than offer a minimum health plan would be allowed to offer supplemental coverage to their employees—commonly known as a "wrap-around" policy. For example, if the current health insurance plan covered dental care, employees would be worse off under the public plan. In this case, an employer might choose to drop its health plan, pay the voluntary tax, and offer a dental insurance plan that would supplement the public plan. In this example, the employees would retain their current level of benefits and the employer would have lower costs if the sum of the tax and the costs of the dental insurance were lower than the costs of the current private insurance policy.

All individuals and families whose incomes were below 100 percent of poverty would be eligible for Medicaid coverage (without cost). Individuals and families whose incomes were above the poverty level could "buy in" to Medicaid based on a sliding scale of contributions. Specifically, the contribution or "premium" would be the smallest of the following:

- Five percent of family income above poverty for each covered family member;
- Ten percent of family income above poverty; or,
- The total cost of Medicaid coverage for an average family of this size.

Single-Payer Public Plan

Under this alternative, the government would be the sole insurer for basic acute-care services. There would be only one comprehensive benefit package, which would be actuarially equivalent to the average benefits that private insurance plans and Medicare currently provide. This universal public plan would cover the services typically included in private insurance plans now and would require copayments by patients up to an annual cap.

The universal plan would cover all legal U.S. residents, financed from broad-based taxes. Private insurers would not be permitted to offer competitive or supplementary insurance (such as the medigap coverage now sold to Medicare enrollees) for services provided under the public plan, but they could cover other services. A residual Medicaid program would supplement the universal plan for low-income people, covering their copayments and some services (primarily long-term care) excluded from the universal plan.

Payment rates for hospital and physician services covered under the universal plan would be set using Medicare's current payment methodologies. For physician services, Medicare's rates would be applied to all services without adjustment, thereby reducing rates now paid by private insurers and increasing rates now paid by Medicaid. For hospital services, two adjustments would be required. First, rates now paid for Medicare enrollees would be increased by about 10 percent because Medicare's payments now cover only about 90 percent of hospitals' costs for treating Medicare patients. Second, for some diagnoses, the rates appropriate for Medicare patients would be modified to reflect the different (generally lower) costs of treating younger people. Hence, both Medicaid and Medicare rates for hospital services

would increase, while average rates paid by private insurers would fall. The net result of these payment rate changes, together with the extension of insurance to those who are now uninsured, would be to increase payments for health care services by up to $17 billion for 1990.

The results shown in Table 1 assume that the public insurer's administrative costs would resemble Medicare's, equal to about 2 percent of the total cost of covered services or 2.3 percent of benefit payments. The results also assume that the billing costs of providers might fall by as much as one-half compared with the current system of multiple insurers. As a result, if payment rates for providers were reduced to reflect their lower administrative costs, administrative costs—for insurers and providers combined—might have been lower by about $22 billion had a single-payer system been in place for 1990.

RESPONSES OF MR. REISCHAUER TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question No. 1. Please provide a written explanation of the method used to estimate the impact of each of the three illustrative plans on federal outlays, tax expenditures, and total federal expenditures?

Answer. For each of the three illustrations presented in Table 1 of the testimony, effects on federal health expenditures are shown as percentage changes in federal spending for 1991. Our estimates of 1991 spending were $220 billion in direct outlays and $71 billion in tax expenditures (including both income and Social Security payroll tax revenues), yielding total federal health expenditures of $291 billion. The estimates shown in Table 1 assume that market reforms would not change federal health expenditures.

The estimates for the tax subsidy proposal were derived from CBO's tax simulation model; although the model is based on the Current Population Survey, it adjusts income using data from the Internal Revenue Service. Simulation of the President's tax credit/deduction proposal shows that about half of all uninsured people would have qualified for the full tax credit had the credit been in place in 1991. If all those eligible for the full credit claimed it (reducing the number of uninsured by half), federal outlays for the credit would have been $16.8 billion, increasing federal direct expenditures for health by nearly 8 percent. In addition, low- and moderate-income people who now have employment-based or other health insurance would gain because of the new tax deductions that would be provided.

If the policy had been in place in 1991, these new tax deductions would have reduced federal revenues by an estimated $27.7 billion, increasing federal tax expenditures for health by 39 percent. Counting both direct outlays and tax expenditures, federal spending for health would have increased by $44.5 billion, or 15 percent.[1] National health expenditures would have increased by about 2 percent.

Estimates for the play-or-pay employer mandate were derived from CBO's insurance simulation model, which is also based on the Current Population Survey. The illustrative proposal examined specifies that the mandate would apply to all employees working 25 hours or more per week and that employers who chose to pay rather than play would be assessed a payroll tax of 7.5 percent (with an additional 2.5 percent assessed on the employee) to finance a new public insurance program. Unless they were covered by another employment-based plan, spouses and other dependents of the employees the mandate affected would have to be covered as well.

The proposal also assumed that all people with family income below the poverty threshold would receive Medicaid at no cost and that those above the threshold could buy into Medicaid at a cost not to exceed 10 percent of income above the threshold. The simulation showed that federal outlays for the new public program would total $33.2 billion (partially offset by revenues from the new payroll tax, which are not shown in Table 1). In addition, federal outlays for Medicaid would increase by $8.3 billion. There would, however, be $4.7 billion less spent for Medicare and Medicaid because more beneficiaries would have employment-based coverage as their primary payer.

The net result on federal outlays for health would be an increase of $36.8 billion, or 17 percent. Federal tax expenditures for health would increase by $6.4 billion (9 percent) because of the increase in employment-based coverage. Overall, federal expenditures for health would increase by $43.2 billion, or 15 percent. Under this option, national health expenditures would increase by about 3 percent.

CBO based the estimates for the single-payer illustration on the National Health Expenditure Accounts, augmented by estimates of the amount of health care that is currently uncompensated. The estimates assume that the single-payer plan would

[1] The analysis assumes that only those eligible for the full credit would purchase insurance if they had not done so before and that all those eligible for the full credit would claim it.

use Medicare's payment rates for physician services but that the rates for hospital services would be increased by about 11 percent to cover hospitals' costs. The insurance plan would cover all U.S. residents and would retain the copayment requirements that typify plans currently in effect.

For 1991, federal expenditures for health would have increased by about 75 percent, or $165 billion, as the federal government paid costs that are now uncompensated or paid by private insurers and state Medicaid programs. Most federal tax expenditures for health would be eliminated, with only about $4 billion in revenue losses from charitable contributions for health remaining. Overall, federal expenditures for health would have been about $98 billion (34 percent) higher under the illustrative plan.

Question No. 2. In your testimony, you state that tax incentive proposals similar to those suggested by the President would result in a net increase of 15 percent in federal expenditures for health care. You further state that "play or pay" models, similar to my own bill, would result in a similar net increase in federal expenditures. How do these two approaches compare in improving access to care for the uninsured?

Answer. CBO's estimates indicate that the tax incentive proposals examined would cut the number of uninsured by about half, so the share of the population covered by insurance would increase from 86 percent to about 93 percent. The play-or-pay option we examined (which differs in several important ways from the Mitchell bill) would increase the insured share of the population to about 97 percent. If market reforms resulted in a significant reduction in insurance premiums, the proportion of the population insured under each plan might increase by another 2 percentage points.

Question No. 3. Do you believe that cost containment must include setting payment rates and establishing a global budget or expenditure target to be effective?

Answer. Although effective cost containment does not necessarily require setting payment rates and expenditure limits on the system, it does appear that policies addressing both price and quantity of services would be essential components of a health care cost-containment system.

Over the past decade, a number of strategies to control health care costs have been attempted, including managed-care insurance arrangements, price controls under public programs, increased competition among insurers and providers, and regulatory changes in the market for health services. Despite those efforts, real health care spending per capita has continued to rise. In fact, the growth rate was higher in the last half of the 1980s—a period that saw significant cost-containment activity—than it was in the first half.

Efforts to control health care spending appear to be frustrated by our fragmented system of financing, under which providers facing constraints on prices and quantity for one set of patients are often able to alter prices and quantities for other patients.

There is evidence, however, that greater control over health care spending might be achieved by a combination of cost-control strategies—if they were implemented uniformly across health care markets (defined as broad geographic regions). These comprehensive and coordinated cost-control strategies would include all-payer rate setting; uniform monitoring of providers to ensure that the quantity of services did not increase to offset reductions in payment levels; and controls over the spread of capital and new technologies. Setting limits on expenditures could increase the effectiveness of those other cost-control strategies. The limits could be set by means of global budgets for hospitals, targets for specific providers or overall health expenditures with penalties for exceeding the target, or an absolute cap on expenditures.

RESPONSE OF MR. REISCHAUER TO A QUESTION SUBMITTED BY SENATOR BREAUX

Question. I will soon be introducing legislation that would create Medical Care Savings Accounts as a new option for employers who provide health insurance to their employees. Under this proposal, employers could move from their current low deductible plans, say $250–$500, to higher deductible plans, with deductibles in the range of, for example, $2,000 to $3,000. The premium for a high deductible plan would be much lower than that for an employer's current low deductible plan. The difference would be given, before taxes, to the individual employee and his/her dependents to cover, in essence, their deductible. The money would be placed in a Medical Care Savings Account and could only be used for qualified medical expenses. Any that is left over at the end of a year could accumulate to cover health care costs during periods of unemployment or long term care services after retirement. Funds spent out of the account for non-medical purposes would be subject to

income tax and a 10 percent penalty tax. At the age of 59½ an individual could roll over any accumulated funds into an IRA.

The individual's knowledge that he or she will be permitted to keep left-over funds will provide an incentive that does not exist under fee-for-service plans to spend money more wisely on health care services. Also, I anticipate that substantial administrative savings could be gained as low-dollar claims would be paid directly by an individual from the Medical Savings Account to their physician, etc. We would avoid the use of expensive and complicated insurance claims forms for these low dollar claims.

Has CBO looked at this kind of proposal and, if so, what conclusions has your office reached? Do you anticipate savings from this kind of proposal? To what extent do you feel that individuals will change their behavior when given the incentives I discussed above?

Answer. Because we have not analyzed proposals of this type in detail, our response necessarily is preliminary. At this time, we think the proposal would add some incentives for people to spend more wisely on health care and therefore would reduce total spending.[2] In general, higher deductible amounts have a substantial impact on the use of health care services. The reduction in spending under this proposal is likely to be small, however, because a large fraction of the population would probably retain their traditional health insurance plans. The savings in administrative costs would also probably be small, because the savings insurance companies realize are likely to be largely offset by the higher costs of monitoring the proposed savings accounts.

THE INCENTIVE TO SPEND MORE WISELY ON HEALTH CARE

When the qualifying health spending of an uninsured person surpasses the deductible amount, the incentive to be cost conscious falls. Before reaching the deductible limit, health care costs are paid out of pocket, thereby reducing the amount of other goods and services that can be purchased. Once the deductible amount is exceeded, the person's share of any cost falls to the rate of coinsurance in the insurance policy. That amount is typically 20 percent of the cost of care provided (generally up to a catastrophic cap). By raising the deductible, this proposal would increase the amount of spending subject to greater cost consciousness.

Furthermore, the proposal could be beneficial to the average insured person. Because the lower cost consciousness that today's typical plans engender has increased spending beyond what people would choose to pay on their own, insurance premiums now are higher than they would be if all consumers compared the value of health care to its full cost. Thus, if the deductible amount were raised and the savings in premiums were deposited in a medical care savings account, the average employee would be able to pay for the desired (lower) amount of health spending and have money left over.

The impact on total health care spending would depend, however, on the number of people choosing the new type of plan over their current insurance. Although the available information is limited on how much premiums might be reduced under this proposal, it suggests that many people would be exposed for some time to greater out-of-pocket costs and might therefore prefer to remain under their current policies.

At present, premiums for a single person with a $250 deductible and 20 percent coinsurance average around $1,400 nationally. If the deductible were raised to $2,500, the premium would decline by roughly $400. Premiums for families with similar plans would drop in roughly the same proportion.

Yet many people would probably prefer their current plans over the savings account proposal because of the risk that they would have substantial uncovered health care expenses before accumulating enough in the account to cover them. For example, a single person who received $400 in contributions to a health care account and made no withdrawals would require—at today's interest rates—more than five years to accumulate $2,500. Furthermore, people might well prefer to maintain more than $2,500 in a health care account to protect against unusually high medical costs that could result in successive years.

People at above-average risk of requiring substantial amounts of health care would probably not choose plans with higher deductible amounts. If a large fraction of the population retained its traditional insurance plans, the reduction in health spending from this proposal would be modest. Moreover, since many who would

[2] Based on conversations with Senator Breaux's staff, this analysis assumes that employees would not be required to have higher deductible amounts and that those who chose to have a medical care savings account would not be allowed to supplement their employers' contributions.

choose the plan with higher deductible amounts would be healthier than average, there would be little excess health spending for the proposal to reduce. In addition, premiums for traditional plans would be higher, although employees in those plans would not necessarily pay more.

ADMINISTRATIVE SAVINGS

The proposal would produce administrative savings because insurance companies would process fewer claims. Individuals would pay more costs directly, by withdrawing them from their medical care savings accounts. The withdrawals, however, would need to be monitored to ensure their application to qualified medical expenditures. The Internal Revenue Service, and perhaps the employer, would need to review the withdrawals much as insurance companies now review claims. Moreover, individuals who met the high deductible amount would have to submit all claims to the insurance company. As a result, the net administrative savings to the country as a whole could be modest.

RESPONSES OF MR. REISCHAUER TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. Why are CBO's estimates of the number of people who would be in the public plan under a play-or-pay option different from the estimates produced by the Urban Institute?

Answer. Our estimates suggest that 18 percent of workers who work 25 hours or more a week would be covered under the public plan. This proportion is smaller than the frequently quoted Urban Institute (UI) estimates for a number of reasons:

- The UI bases its estimates on a threshold of 18 hours compared with CBO's illustrative threshold of 25 hours. If workers with fewer than 25 hours were included in the CBO estimates, more firms would decide to pay the tax rather than offer insurance.
- The UI assumes that a much more expensive minimum plan would be required—about 25 percent more—than the one CBO used in its analysis. If the required private plan is more expensive, again more firms would decide to pay the tax.
- The UI uses a data base (County Business Patterns) that provides the total payroll in each state by establishment (not firm) size and industry. As a result, the UI estimates that a higher proportion of workers are employed by establishments that would choose to pay the tax. Using establishments rather than firms tends to increase the number of units that would take that option rather than offer insurance. This result occurs because many establishments with low-wage workers are branches of larger firms that have high-wage workers in other establishments. Across the entire firm, the payroll per worker might be high enough to make the tax an unattractive alternative, even though individual establishments might choose to pay the tax ~~if they~~ were allowed to make independent decisions.

Question No. 2. I have a question about Medicare's administrative costs. The direct administrative costs of the Medicare program are low, as I understand it. Do you know of any estimates of the cost of the administrative burden that Medicare imposes on providers and beneficiaries who participate in it?

Answer. CBO is not aware of any studies that attempt to document the costs insurers impose on beneficiaries. In 1988, however, the American Medical Association (AMA) studied the costs physicians incur in collecting payment for patients insured by Medicare and Blue Cross. The survey results showed that—per claim—those two insurers imposed roughly the same administrative burden; that is, filing Medicare claims was no more onerous than filing Blue Cross claims. The AMA estimated that physicians spent an average of six minutes per claim, while office staff spent an average of 60 minutes. For those physicians using an outside billing service, costs averaged about $8.20 per claim. The Spring 1992 issue of *Health Affairs* reported more recent results for both physicians and hospitals ("O Canada: Do We Expect Too Much From Its Health System?" by John Sheils, Gary Young, and Robert Rubin). Those estimates indicate that collection costs account for 8.3 percent of physician revenues and 3.6 percent of hospital revenues. Like those reported by the AMA the figures in Health Affairs include the costs of collecting from patients as well as insurers.

Question No. 3. In assuming that a Medicare-like single payer system would have administrative costs similar to those for the current Medicare program, shouldn't we factor in the administrative costs incurred by private parties who participate in the program when we try to estimate administrative savings which would flow from adoption of such a plan?

Answer. The estimates presented for the single-payer system in Table 1 of the testimony incorporate estimates of billing costs for providers. CBO assumes that those costs would decline under a single-payer system because providers would no longer have to deal with many different insurers, each with a different set of requirements for filing claims. Although filing costs that patients incur would also be reduced (or even eliminated if providers filed all claims), savings to patients are not included in the single-payer estimates. There are two reasons for that. First, we have no estimates of current costs to patients. Second, these costs do not constitute a component of national health expenditures as usually measured.

RESPONSES OF MR. REISCHAUER TO QUESTIONS SUBMITTED BY SENATOR WELLSTONE

Question No. 1. There is debate about the actual impact of cost-sharing on the use or cost of health services. In fact the only utilization that is generally affected is the decision to seek possibly necessary primary care, which could in turn increase the cost of later treatment. At the same time, the absence of cost sharing would encourage early treatment for preventable diseases. It would also eliminate the administrative expenses associated with fee collection and the determination of eligibility for various levels of cost sharing. Would you please elaborate on the costs associated with cost sharing under our current system, what the projected effect of a plan without cost sharing would be on the chart presented on page 6 of your testimony, and explain the basis for that projection?

Answer. The single-payer plan examined in Table 1 would retain the cost-sharing levels that currently typify private insurance and Medicare. Because of savings from lower administrative costs and lower payment rates under private insurance, this plan could extend coverage to the whole population and raise the rates Medicare and Medicaid pay to cover hospitals' costs—with no increase in national health expenditures. If the plan had no copayment requirements, national health expenditures will increase—by up to 10 percent. A small part of that increase would result from eliminating the bad debt that some patients now impose on providers. Most of the increase, however, would stem from the greater use of services that would occur if patients faced no copayment requirements. If the single-payer plan imposed effective constraints on the unnecessary use of services, some or all of that increase might be prevented.

If a federal single-payer plan had no copayment requirements, the increase in federal outlays would become twice as large as shown in Table 1—about 150 percent instead of 75 percent. The outlays would be larger than shown not only because of patients' increased use of services but also because the share of costs for insured services the single payer handles would rise from about 85 percent to 100 percent. The effect on federal tax expenditures would be unchanged, so that the overall percentage increase in federal expenditures for health would be about 90 percent instead of the 34 percent shown.

Question No. 2. Please comment on the likely effects on cost, access, and the likelihood of two or three tier health care, created by the sort of managed competition suggested by Alain Enthoven.

Answer. We have not formally analyzed Professor Enthoven's latest managed-competition plan. We are, however, planning to examine some of the key ideas in the Enthoven plan, and we will provide the results of that analysis to you when it is completed.

Question No. 3. Community rating was the method originally used by Blue Cross and Blue Shield to price its insurance policies. Please comment on factors leading to the demise of community rating, and the likely effectiveness at this juncture of reinstituting community rating in a competitive market-based system in expanding access to care and controlling costs.

Answer. Competition by commercial insurers for the health insurance market once dominated by Blue Cross/Blue Shield (BC/BS) has virtually eliminated the practice of community rating. "Cherry picking" among potential clients, commercial insurers were able to siphon business away from BC/BS by offering lower premiums. The principal means was to seek out employers with a healthy, low-cost work force and offer them an experience-rated premium.

As cherry picking became significant in an insurance market, BC/BS was forced to raise the community rate it offered because the pool it retained was less healthy and therefore more costly. Those premium increases provided commercial insurers with more opportunities to select the healthiest groups among those remaining in the BC/BS pool. Ultimately, to compete with the commercial insurers, BC/BS had to offer experience-rated premiums to large employers. Otherwise, they would have become only the insurer of last resort for groups the commercial insurers did not want to deal with.

Reinstating community rating would be feasible if it were required of all insurers and if transition provisions were implemented to avoid penalizing those insurers (like BC/BS) who now enroll a relatively high-cost population. Unless a reinsurance mechanism accompanied the requirement for community rating, however, smaller insurers would probably leave the market because they would be unable to manage the risk that comes with a community-rated market.

Community rating would assure high-risk people access to insurance, but it would probably not increase overall insurance coverage significantly. Instead, it would probably bring about some redistribution of coverage, from low-risk people to high-risk people.

Although community rating would make health insurance more affordable for high-risk people, it would do nothing to control the aggregate costs of health insurance or medical care. In fact, the return of community rating would increase somewhat aggregate health insurance premiums, if the insured population included more high-cost people than it does now. If medical underwriting were eliminated in a community-rated system, there would be an offsetting reduction in costs and hence in premiums; but underwriting would continue to be necessary for small insurers faced with the need to reinsure high-cost enrollees in order to manage their risk effectively.

[SUBMITTED BY SENATOR DONALD W. RIEGLE, JR.]

U.S. SENATE,
Washington, DC, December 13, 1989.

Hon. GEORGE H. BUSH,
President of the United States,
1600 Pennsylvania Avenue, N.W.,
Washington, DC.

Dear Mr. President: I am writing to urge your support and active involvement in moving now to develop a comprehensive national health program to provide health insurance coverage for all Americans.

The urgent need to provide health care coverage for people without health insurance is underscored by recent sharp increases in Blue Cross/Blue Shield and other private insurance coverage as a result of repealing the Medicare Catastrophic Coverage Act of 1989. In Michigan alone, rates are expected to rise 46 percent.

As you know, this is Only a symptom of a much larger problem within our health care system. It is increasingly difficult for people to purchase affordable and comprehensive health care in this country. Our current health care system not only leaves many gaps in the extent of services offered, but some 37 million people have no health insurance at all. An estimated 12 million of the uninsured are children. We need to reform the current system so that affordable, comprehensive health care is available to all Americans.

I serve as a member of a bi-partisan working group in the Senate that is developing a public and private sector solution to the problem. This group began meeting in July and plans to introduce legislation early next session in time for the fiscal year 1991 budget cycle.

The political and business climate has changed dramatically on this issue. A new group of leaders has emerged in the Senate who are working with business, labor, and health care providers. This task is a moral and economic necessity. In order for America to compete in the world market place, all Americans have to be full partners—and good health for themselves and their families is essential to their performance.

It is most important that you express the willingness of your Administration to take the lead on this vital issue and share with the Congress your thoughts and suggestions on how best to develop a comprehensive national health program. As Chairman of the Subcommittee on Health for Families and the Uninsured of the Senate Finance Committee, I stand ready to work with you to accomplish this most vital goal.

Thank you for your consideration.

Sincerely,

DONALD W. RIEGLE, JR.

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, May 10, 1990.

Hon. DONALD W. RIEGLE, JR.,
U.S. Senate,
Washington, DC.

Dear Don: I am responding to your letter to President Bush regarding your evaluation of the current status of health insurance coverage and your efforts to develop a comprehensive national health program.

I, too, am deeply concerned that too many Americans do not have any or adequate health insurance coverage. Last September, I directed Constance Horner, my Under Secretary, to lead a task force to prepare recommendations for the reform of our health care financing policies. Among the options being explored are ways to create a partnership between Federal, State and local governments and the private sector to strengthen the health care delivery system and make it more responsive to the needs of the poor and the uninsured. In addition, I will personally be leading a Domestic Policy Council review of recommendations on the quality, accessibility and cost of our nation's health care system.

The Policy Council will be reviewing the recommendations of the Pepper Commission, the Advisory Council on Social Security, your bipartisan Senate working group, and our Department Task Force, as well as other proposals. After carefully considering each of the proposals, we will make a recommendation to the President. greatly appreciate your offer to work with the Administration as we explore ways to improve our nation's health care system. I look forward to a continuing dialogue with the Congress on this important task.

Sincerely,

LOUIS W. SULLIVAN, M.D., *Secretary*

THE WHITE HOUSE,
Washington, December 18, 1989.

Dear Senator Riegle: Thank you or your recent letter to the President providing your evaluation of the current status of health insurance coverage and your efforts to develop a comprehensive national health program.

We appreciate being apprised of your interest and your perspective on this issue. I have taken the liberty of sharing your comments with the President's health care policy advisors so that they, too, are aware of your efforts.

Thank you again for your interest in writing.

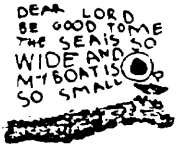
With best regards,

Sincerely,

FREDERICK D. MCCLURE, *Assistant to the President for Legislative Affairs.*

Children's Defense Fund
C Street, N.W.
Washington, D.C. 20001

phone (202) 628-8787



February 10, 1992

President Bush's Health Plan Fails Children

President Bush's health care reform package is a hoax. The President's health care plan offers very limited help to millions of American middle income and poor uninsured children while it takes away from poor children in Medicaid. The President's proposed tax deductions and credits will not provide an insurance card, doctor, or clinic to a single American child. Tax credits cannot heal a child's strep throat or correct a vision problem. But, the proposed cutbacks in Medicaid will make it even more difficult for poor children to get the health care they need.

The President's proposal offers a $3,750 tax deduction on health insurance costs for families earning less than $80,000 per year. The proposed tax deduction is regressive because it benefits higher income families more than it helps lower income families struggling to pay their health care bills. For a family of three or more earning $70,000 in the 28 percent tax bracket, the deduction is worth up to $1,050. However, for the same family earning $25,000 in the 15 percent tax bracket, the deduction is worth a maximum of $562.50. Lower income single parent families with just one child would receive even less, only $375 in tax savings -- enough to buy about one month's worth of health insurance.

The health insurance tax credit will do little for uninsured low-income children. Families with incomes less than 150 percent of the poverty level would be eligible for a new health insurance tax credit worth up to $3,750 to the poorest families with three or more members, too little to buy decent health coverage in many areas in the country. The tax credit is phased-down so that a family of three or more earning 150 percent of the poverty level (about $20,000 for a family of four) would receive just $375. A single parent with just one child earning about $13,000 would receive only $250 from the tax credit.

The details of the President's health insurance tax credit are still sketchy, but according to the Wall Street Journal, only families with incomes less than 50 percent of the poverty level (less than $7,000 per year for a family of four) would be eligible for the full credit during the first year -- families

whose children are nearly all eligible for Medicaid now. Other poor families with children would receive a smaller tax credit, although they are far too poor to pay the difference between the credit and the cost of private health insurance.

To pay for the tax credits and deductions, the President proposes major cutbacks in the Medicaid program. His plan would cap Medicaid expenditures on a prospective basis and shift the effect of rapidly rising health care costs onto the states. The Administration's plan would alter the current federal-state arrangements that provides federal funding based on the actual cost of providing benefits to Medicaid recipients to a system that would give states a per capita payment that could rise no more than 2 to 4 percentage points above overall inflation regardless of how much a state might actually provide for Medicaid beneficiaries or how high medical costs actually rise. Given the rapid rise in health care costs, the proposal would simply shift the effect of medical care inflation from the Federal government to states, further increasing the pressure of Medicaid expenditures on state budgets.

Along with a cap on Medicaid expenditures, the President proposes to reduce the benefits for children and pregnant women in Medicaid. States would be allowed to offer a "basic" health plan which provides far less than what current beneficiaries are entitled. Examples of "basic" plans proposed by the Administration would limit doctor visits to as few as three per year and would not include coverage for prenatal care and would require copayments from poor families. Only low-income pregnant women and children, AFDC recipients, and the disabled would suffer these cutbacks, since the President's plan exempts all other Medicaid recipients and long-term care costs from this new system.

The President's proposal also gives states the option to eliminate their current Medicaid programs and replace it with a new program based on the proposed tax credit. States would receive a lump sum payment from the Federal government to provide a "basic" benefit package for the poor with none of the minimal protections now required under current law. Coverage of services such as prenatal care and immunizations and well-child visits would no longer be required. The President's proposal would also eliminate coverage for millions of young children and pregnant women with incomes above the poverty level who are currently eligible for Medicaid.

Funding health insurance tax credits for uninsured families by cutting benefits from low-income children covered by Medicaid is tantamount to stealing from the poor to give to the destitute. American children need health care like that given to children throughout the industrialized world, not health insurance tax credits. It is shameful that the President's inadequate proposals are funded by cynical cuts in benefits from politically powerless low-income children, pregnant women, and disabled persons. We urge Congress to reject the President's package and move forward on real health care reform.

PREPARED STATEMENT OF SENATOR WILLIAM V. ROTH, JR.

Thank you Mr. Chairman. This Committee has held several hearings on the nation's health care crisis this Congress and I believe that today's hearing to examine what proposals have been put forth will continue to help us in developing the appropriate means of reforming the nation's health care system. I join my colleagues in commending you for holding today's hearing.

In particular, today's hearing will help us better examine the costs and benefits trade-offs of different comprehensive proposals. I am particularly interested in today's testimony on managed care and competition as I am working on developing a plan which encompasses many of these principles.

The plan I am developing would begin by transforming the Federal Employee Health Benefits (FEHB) program into a more managed care oriented plan and then opening up the plan for buy-in by the small business community. Today, FEHB is already covering 9 million individuals in virtually every locality in the country.

Those enrolled in FEHB enjoy quality health care at a large group rate, which I propose to extend to the 26 million working uninsured. I will be addressing this type of reform in my questions.

Consensus in health care reform among members of Congress, experts and the public is far from being reached, yet we are moving forward. In fact, a week ago today, I was pleased to see a step forward made with the formal establishment of medical billing audit guidelines. The standardization of these industry developed audit procedures that these guidelines include combined with the standardization of billing procedures currently taking place in the industry, will greatly reduce administrative costs. These costs currently make up about 20% of medical bills, so naturally, consumers will ultimately benefit.

Yet, the process for achieving this advancement was lengthy. In 1989, I held hearings at the Permanent Subcommittee on Investigations that revealed widespread corruption in the health care revenue recovery industry. Scams uncovered showed that hospital bill auditors paid on a contingency fee basis were embellishing charges while ignoring instances where the hospital had overcharged the patient. Then in 1990 and 1991 I introduced legislation to achieve "Fair Auditing."

Finally, for over a year, my staff and I worked with a group of industry representatives to develop the guidelines finally issued on April 30th.

I believe billing reform is a fundamental part of health care reform. Today, there are tremendous financial pressures on hospitals who daily provide care to uninsured individuals. There are also great financial pressures on those left paying the costs of these unmet bills. The juncture of thee pressures is the medical bill. I am convinced that before widespread health care reform can be achieved, the basics—such as billing practices—must be brought into line. It is my hope that these new guidelines will bring back truth in billing.

Our health care system is touted as being both the best and the worst of all the developed nations. The worst because millions of individuals lack access to affordable quality health care; countless unneeded medical procedures are performed; and billions of dollars are spent on administrative costs and paperwork instead of on care. Yet, our nation's health care system is seen as the best in fostering innovation; delivering care; and the quality of providers and facilities. It is my hope that reform will keep the best of what we have and whittle away at the worst.

PREPARED STATEMENT OF JERALD R. SCHENKEN

Mr. Chairman and Members of the Committee: My name is Jerald R. Schenken, MD. I am a physician in the practice of pathology in Omaha, Nebraska. I am also a member of the Board of Trustees of the American Medical Association. Accompanying me today is Carol O'Brien, JD, of the AMA's Legislative Affairs Group. The AMA appreciates this opportunity to appear before the Senate Finance Committee to discuss our concerns about the spiraling cost of health care in this country.

Like the Committee, the Administration, and an increasing number of experts and concerned citizens, physicians are pledged to action to address the problems of the estimated 34 to 37 million people in the United States who lack health insurance and have limited access to needed medical care, while health care costs for all segments of the population continue to increase.

As patient advocates, we are concerned about the economic constraints that force some of our patients to postpone or go without needed care. In recognition of the serious economic problems many of our patients face in this recession, the AMA calls on all physicians to eliminate balance billing for those patients under 200% of the poverty level.

This action will enhance the existing record of physicians consistently providing care for those patients who cannot afford it. Last year American physicians contributed $6.8 billion in free and reduced fee medical care.

Physicians recognize that we cannot independently reduce health care costs or guarantee access to care. The problem of soaring health care costs is singularly complex and of enormous proportions. Broad-based private and public reforms must be initiated across all sectors of the health care industry if concerted action in paring down costs, while maintaining meaningful access and quality of care, is to be effective.

Today, I will address the AMA's concerns about the continued growth in health care spending and the increasing problem of Americans who lack ready access to care. Unfortunately, such individuals must rely on inappropriate, expensive modes of care, such as hospital emergency departments, if indeed they receive any care at all. I also am pleased to discuss the AMA's Health Access America (HAA) proposal to promote access through the provision of coverage for basic health care for all Americans and significantly reduce health care spending and administrative costs.

HEALTH CARE COSTS

When a nation spends $666 billion per year for health care and yet 13% to 15% of its citizens are uninsured and have difficulty attaining health care services in an environment of increasing costs, the problem poses extreme concern. The AMA is concerned, too, that expenditures reflect real benefits from care. We support efforts to achieve humane, meaningful, long term cost containment in health care expenditures. But, this must be accomplished without jeopardizing access to and quality of care. Research must continue to pinpoint how and why health care spending is increasing and to determine what policies will most effectively mitigate this trend. Cost cutting through purely budget driven mechanisms will not prove cost effective or socially redeemable if the end result is reduced access, poorer outcomes, rationing of essential care and misallocation of resources.

It is important to recognize at the outset that physicians represent only a small portion of overall medical care costs. Total expenditures, including hospital, nursing home, pharmaceutical and durable medical equipment costs, have all increased at rates well in excess of general economic growth, with nursing home expenditures increasing the fastest from 1970–1990.

AMA efforts—as well as others in the private and public sectors—will continue to seek control of escalating health care costs through legislative and other reforms. We have also urged hospitals to make available to attending staff, hospital housestaff and medical students permitted to work in that hospital, a list of commonly requested diagnostic tests and prescribed medications and their corresponding charges. Similarly, we support fee and price disclosure by physicians, hospitals, pharmacies, durable medical equipment suppliers and other health care providers prior to the provision of service.

Studies show that from 1984–1989, the number of physician and hospital visits either fell or remained constant, although per person health expenditures increased dramatically. A recent study by Jencks and Schieber in the 1991 Annual Supplement of *Health Care Financing Review* (March, 1992), published by HCFA, suggests much of the recent growth is the result of increases in price and intensity per unit of service and not in the volume of services provided. Other studies published in 1991 and early 1992 corroborate this trend, pointing out that technological and cost containment advances reduce inpatient activity, and promote surgical and other intensive procedures. This is reflected by the statistically significant growth in ambulatory surgery. These and other technologically driven trends have resulted in shifts, but not necessarily changes, in health care costs.

While it is difficult to disentangle the many forces that have generated the growth of health care costs, an emerging consensus from a number of health care economists indicates that various factors are at work.

INSURANCE COVERAGE AND PREMIUM SUBSIDIES

Restraints on demand for services are very weak because third party insurers pay most costs. The problem is compounded because so few people pay the full cost of their premiums. Even those who do face cost sharing have great difficulty evaluating the reality of what services can accomplish given today's virtually unlimited expectations of modern medicine.

NON-PRICE COMPETITION AMONG PROVIDERS

When insurance weakens price competition among providers, they may compete primarily by seeking to provide more complex and thorough, but not necessarily

more effective, services. Consumer expectations and in some cases demands for more technology as being indicative of "better" care also fuels this phenomenon.

DEVELOPMENT OF TECHNOLOGY

The medical technological explosion of the 1980s has wrought significant and far-reaching changes in health care delivery. Technological advances have resulted in a significant substitution of outpatient for inpatient care. The result has been an explosion in outpatient surgery and diagnostic testing for hospital outpatient departments, freestanding surgery and imaging centers, laboratory services and physicians' capabilities to provide even more extensive office services.

New technologies, such as endoscopy, angioplasty, MRI and CAT scan imaging methods and ultrasound have increased costs and contributed significantly to volume/intensity growth. Studies show that expenditures for diagnostic X-ray studies, radiation therapy and diagnostic laboratory studies were the fastest rising components of services in the late 1980s. Moreover, as with any new technology, initial and capital costs are high and may not result in immediate savings.

It also is undisputed that for many treatments and procedures, new technology has resulted in less risky, less invasive and less painful procedures, as well as substantial improvement in patient outcomes, recovery and return to productivity.

Some 35% of certain surgical and other procedures have shifted from hospital to outpatient settings, resulting in far greater quality through reduced or eliminated hospital stays. Procedures such as arthroscopy, laparoscopy and lithotripsy greatly reduce the risk of nosocomial or hospital-caused infections, surgical complications, and eliminate or greatly minimize patient pain and suffering, morbidity and recovery time.

New technologies necessarily drive up costs initially; but such technology has resulted in improved outcomes and significant savings in some cases, with the potential for much more.

The recent and unprecedented growth of medical technology in the U.S. requires careful study to determine whether individual technologies are capable of achieving improved quality and longterm cost-effectiveness. The AMA supports outcomes research and technology assessment to determine the effectiveness of treatments.

ADMINISTRATIVE/PROFESSIONAL LIABILITY COSTS

Physicians' overhead costs in the United States are higher than in other countries due primarily to the cost of soaring professional liability premiums and defensive medicine costs which require greater utilization of the latest technology. During the 1980s, professional liability expenses rose dramatically, growing by 108%.

Insurance costs and fears of litigation led to sweeping increases in defensive medicine. For example, just ten years ago, many obstetricians avoided the use of fetal monitors, except for high risk patients, as intrusive and counter to the more humane, family oriented childbirth experience demanded by their patients. Some OBGs believed wide use of the monitors would lead to more, perhaps unnecessary, Caesarean deliveries.

Today, use of the fetal monitor during childbirth has become standard, due in large part to liability concerns. Concurrently, the number of Caesarean births has increased, for a number of related reasons, from 5.5% of all births in 1970 to 23.8% in 1989.

Diverse billing and verification procedures also substantially increase providers' administrative costs. Just as administration costs for public programs have increased, so have office expenses for physicians. Studies show that physician practice expenses have increased rapidly—by 47%, adjusted for inflation, from 1982 to 1989. Many physicians must hire additional staff, who must spend increasing amounts of time handling government and private billing and insurance matters. The cost of small group health insurance, workers' compensation, salaries and medical equipment also continue to rise.

Some studies have projected that the adoption of a Canadian-type, single payor system could substantially reduce health care spending, merely by eliminating or streamlining administrative costs. Other studies, however, point out that half of U.S. administrative costs are attributed to functions that would be largely unaffected by changes in reimbursement method, including professional liability, quality assurance, medical supplies and nonphysician medical staff. U.S. administrative costs reflect a higher level of capital reimbursement which cannot be eliminated in the short run. Moreover, claims adjudication costs in the U.S. under a single payor model will still remain higher than Canada as a result of broader due process rights guaranteed by the U.S. Constitution. These studies suggest further that the very

features of a single payor system that would reduce administrative costs would also increase health spending by encouraging greater use of services.

There is no easy solution to the growing problem of health care access and cost in the United States. The health care problems of the U.S., like the enormous size and diversity of the country itself, are highly distinguishable from our European and Canadian counterparts. Our enormous societal and health problems and the sheer size of our citizenry militate against the adoption of a single payor program for budgetary and efficiency reasons.

What is clear is that long term, effective solutions to achieve the difficult goal of cost containment in the U.S. must be grounded on accepted empirical evidence, encompass our societal values and include both the private and public sectors. An effective system must strive to first eliminate unnecessary spending by helping consumers to utilize health care services cost-effectively and provide disincentives for over-utilization. The AMA advocates physician sharing of cost/fee information with patients as well as the development of practice parameters to aid in assuring the provision of appropriate care.

AMA PROPOSAL TO REDUCE HEALTH CARE COSTS

The AMA believes health care spending can be reduced and considerable savings achieved through the implementation of a national health policy that will capitalize on existing resources, streamline spending and extend health care services to all equitably and efficiently. The following points, set out in our Health Access America proposal, summarize the AMA's recommendations to abate inappropriate health care costs and achieve the private/public partnership this country desperately needs to attain substantial health care reform.

Practice Parameters

Inappropriate care inflates health care costs. Evidence indicates that rates of health care services such as prostate, back and coronary artery surgery, as well as diagnostic procedures such as angiography, vary widely among states and regions. Further evidence indicates substantial disagreement on indications for performing such procedures. The AMA is a leader in the development of practice parameters, and we support further measures to enhance the value of every health care dollar spent. Appropriate parameters must continue to be developed by the medical community to reach a consensus on the most effective treatments for a given condition and to enhance the value of care by eliminating ineffective treatments and care. Effectiveness research, education and peer monitoring offers the most substantial means of improving the cost/effectiveness ratio necessary to achieve any meaningful overall reduction in cost.

Technology Assessment/Outcomes Research

The AMA supports outcomes research with technology assessment to determine the effectiveness of medical treatment based on existing new technologies. The AMA's Diagnostic and Therapeutic Technology Assessment (DATTA) program was established in 1983 as a means to develop consensus on medical technology and services. An example of the potential health and cost impact of this activity is seen in the DATTA assessment of the FDA approved (1985) Garren gastric bubble. Our evaluation, completed in 1986, concluded that the device should be investigational and that long-term studies were needed. Subsequently, the labelled use of this devise was substantially modified. Use of this technology moderated from roughly 20,000 implanted prior to 1987 to about 500 subsequent uses of this device.

Managed Care

The AMA is working with a number of organizations to assess the effectiveness of the variety of approaches designed to control utilization and cost of health care known as "managed care." The AMA believes that the concept of managed care contains significant potential for constraining health care spending. However, the AMA does have concerns that managed care, when improperly conducted, can interfere with clinical decision-making, reduce access to needed services and in turn jeopardize patient care and outcomes.

Physicians will continue to meet with representatives of payor groups involved in the development and marketing of managed care plans. We believe that jointly agreed-upon guidelines for the structure and operation of managed care programs are needed to prevent duplication and increased costs. Such voluntary guidelines would encourage access and would not impair the physician's clinical decision-making. These guidelines would be widely distributed to physicians and payor groups and could serve as the basis for the development of needed legislation.

Reducing Administrative Costs

The proliferation of health care forms and administrative procedures from varying third party payors and government programs is inefficient and costly. All insurers should be required to use the same claim form, the HCFA 1500. Federal law should require the development of a uniform system of electronic billing to both cut administrative costs and speed billing and cash flow. Physician and others need the option of access to such an electronic claims system. Burgeoning technology relating to patient identification and record keeping also needs to be explored for administrative savings.

Essential Benefits, Not State Mandates: ERISA Reform

Employer-provided health insurance should continue to be the backbone of coverage for the majority of Americans. But state mandates of expensive services drives up costs, making benefits too costly for a number of employers. The AMA supports preemption of state benefit requirements and a requirement for employers to provide an essential benefits package, such as that developed by the AMA for Health Access America. Similarly, all plans should operate under the same rules. Exemptions for self-funded plans now applied under the federal Employee Retirement Income Security Act (ERISA) should be eliminated.

Liability Reform

In 1989, an estimated $20.7 billion was attributed to defensive medicine and liability insurance premiums. Studies have shown this problem cannot be redressed by changing who provides the reimbursement to physicians. Failure to significantly address liability has already resulted in reduced access to obstetrical, neurological and other high risk care specialties in many parts of the U.S. This serious matter must be addressed in the process of taking steps to reform how our health care system operates. Legislation such as S. 489, the "Ensuring Access through Medical Liability Reform Act of 1991," introduced by Senator Hatch, will address the complex issues of the medical liability environment that drives up costs and hinders access to essential care.

ANTITRUST CONCERNS

The AMA recommends that medical societies be allowed to review fees, to arbitrate a fee and to mediate voluntary fee agreements between patients and physicians. Currently, efforts of local medical societies to police or arbitrate patient disputes concerning fees are discouraged by antitrust laws. The AMA recently asked the Federal Trade Commission (FTC) for the regulatory authority to review physician fees and to discipline physicians who charge excessive fees. Under this contemplated program, state or county medical societies would perform most professional peer review of fees. State societies would also act as appellate bodies for opinions or decisions of the county societies, and the AMA would participate as the appellate entity for the state societies.

The AMA strongly recommends the implementation of a peer fee review program as consistent with FTC recognition that properly managed, professional fee peer review can yield important pro-competitive benefits, and will serve to protect and promote the interests of patients—the consumers of medical services.

Insurance Reforms

Insurance reforms are necessary to reduce administrative costs and to increase the availability of affordable insurance. Such reforms should include subsidized state risk pools, the elimination of preexisting condition limitations, community rating and portability and continuity of coverage that will allow an employee and his or her dependents guaranteed coverage in the event of a job change. Portability and the elimination of preexisting condition limitations will lower costs associated with extensive risk underwriting designed to attract only low risk individuals.

Community rating and open enrollment, will allow premiums charged to small groups to be comparable to the per capita average of all the group insurance sold in the same community for the same benefit package. This approach would eliminate the current discrimination against small employers that leaves a significant number of working Americans uninsured or underinsured.

Insurers should be required to offer one policy with the same required minimum benefits. A maximum annual cost exposure for the mandated minimum benefits package should be allowed, with carriers required to participate in a reinsurance pool. Self-insurers should also help underwrite the reinsurance pool.

Finally, over-insurance must be discouraged. Patients must be sensitive to the actual costs of care. Studies show that co-payments and deductible have had positive impacts on reducing unnecessary utilization. Patients should be empowered by tax

incentives and health IRAs, as well as access to fee information and cost sharing, to discourage unnecessary spending and utilization. Health IRAs should be enacted to allow citizens to save for health care and utilize their own pretax dollars from tax-free accumulations for health care purposes.

RATE SETTING/GLOBAL BUDGETS

Some proposals have focused on the use of a single rate or the establishment of global budgets as the means to address the health care cost issue. While these concepts certainly should be discussed, we have serious reservations regarding directions that will divorce payment levels from the needs for care.

Extension of Medicare Rates

Some proposals advocate the extension of Medicare rates and policies to all payors. As we have said previously to this Committee, it is premature to consider extending the Medicare payment system to private insurers. The Medicare program should not serve as the standard payment system because it is subject to budget actions driven by federal deficits and an inadequate financing structure. We also are deeply concerned that extension of Medicare rates represents a move toward a single payor system and federal price fixing that ultimately will lead to patient dissatisfaction with a health care system that is driven by political forces rather than patient needs.

Global Budgets

Proposals that advocate the establishment of a target or global budget also raise significant concerns because they substitute the concept of total costs for patient needs as the determinant for health care decisions. As physicians, we see major problems with an approach eventually is certain to conflict with our ethical responsibility to put the patient first.

CONCLUSION

Mr. Chairman, in conclusion, I would like to reiterate that the problem of containing health care costs will not be solved immediately. Rather, this substantial concern facing all Americans must be addressed carefully, consistently and incrementally. Numerous steps can be taken now. Provider and patient education and autonomy also are crucial if we are to achieve real gains in the next decade. The effort must begin now, in ways that build upon our current system and strengths, but eliminate duplication and obvious inequities.

Actions can be taken in this Congressional session. Incremental reforms such as many of the items in S. 1872 can and must go forward to make coverage more readily available and to address matters such as the professional liability crisis, Actions can be taken that will allow the market forces to operate in ways that will empower our patients to make better informed choices and encourage competition. Research must continue to ensure that our technological growth and use of resources is more cos-effective and linked to improved outcomes and quality of care. The AMA is eager to participate in this effort.

PREPARED STATEMENT OF PAUL STARR

Mr. Chairman, I appreciate the opportunity to join this morning's discussion. The uncontrolled growth in health costs and heightened insecurity about health insurance coverage in America today are not only an index of problems in our health care system. They are also an index of political and private-sector failure. We have had twenty years of well-intentioned efforts by government and employers to stem rising health costs within the existing system of insurance. Yet during the 1980s the health sector grew by an additional 1 percent of the GNP every forty months. The current dynamic of rising costs and eroding coverage threatens interests great and small, from mighty corporations that face staggering benefit costs to millions of uninsured working families unable to afford decent care for their children.

Our record looks especially dismal in international perspective. From 1945 to the early 19705, health care costs increased everywhere in the West as a percentage of national income. In recent years, however, the health sector's relative growth in the U.S. has run far ahead of its growth elsewhere. In 1989 (the latest year for which international data are available), the leading nations in Europe and North America, as well as Japan, spent an average of 7.4 percent of national income on health care. America's 11.6 percent that year was by far the highest. Per capita, the United States spent 40 percent more on health care than Canada, the second highest spender, and twice as much as major European nations, all with universal health

insurance. And since 1989, the 11.6 percent of GNP we spent on health care has risen to more than 13 percent and seems headed for 17 percent or more by the end of the decade.

To most Americans lucky enough to be insured, the health insurance premiums taken out of their paychecks feel just like a tax—a tax whose annual increases their representatives in Congress and the White House have failed to control.

Imagine if over the past twenty years we had been able to keep health spending down to European—or even Canadian—levels: It would have been equivalent, in certain respects, to a vast tax cut, releasing private income for many other purposes.

Imagine the impact on government, too. The growing cost of health programs has crowded out other needs from public budgets at all levels. That crowding out is one reason for the disturbing shift in the composition of public expenditures over the past three decades from investment to consumption. This, too, does damage to the national interest.

As if the direct costs of health care were not enough, the U.S. economy is also suffering from indirect effects of our health care system. Take the following three examples:

1. According to recent surveys, three out of ten Americans say they or someone in their household have been unable to change jobs because of pre-existing health conditions that would be excluded from coverage by their new employer. When people are deprived of their freedom to change jobs, the economy is also deprived of the potentially greater contributions they could make elsewhere.

2. While the insurance system locks some into jobs, it locks others into welfare. The principal alternative to welfare lies in low-paying jobs that rarely carry health benefits. Consequently, millions on welfare find that if they work, they cannot have secure access to health care. Welfare lock, like job lock, hurts productivity—and raises costs for government.

3. Conflicts over health benefits have become our leading cause of strikes, thereby also reducing productivity.

Job lock and welfare lock due to limited health coverage and strikes over health benefits are virtually unknown in the rest of the world's advanced economies. We inflict these distinctive economic harms upon ourselves. For the past two decades, we have told ourselves that America could not afford universal health coverage, even as other countries that guaranteed it both spent less for health care and avoided the damaging side-effects of our restricted and shrinking insurance system.

About ten years ago I wrote that the very meaning of national health insurance was changing from a way to increase health expenditures to a way to contain them—but that the country's leaders had failed to comprehend the change. I hope we are now at a turning point. The demand for health insurance security—and I stress the word "security" because the problem affects people with coverage as well as those without it—is a great, historic opportunity to rebuild our health care financing system and change its underlying incentives and organization.

And that is precisely what we need to do: There is a world of difference between cost containment measures superimposed on the present system and cost containment that is embedded in the very structure of an alternative framework. The first has been, and will continue to be, not only ineffective, but the source of more bureaucracy, yet higher administrative costs, and increasing frustration and anger from providers and patients alike. Only when we face up to the full problem, and accept the need for systemic change, will we have any hope of remedy.

The ultimate objective of systemic reform, as I see it, is to reach deep inside the process of health care and change the way everyone concerned—doctors, patients, managers—thinks about the decisions they face. At the core of the problem are the "practice styles" of physicians, governing their everyday choices about when to order tests, hospitalization, surgery, prescriptions, further visits. Reform works best when it promotes a high-quality but conservative practice style—conservative in the sense of conserving resources. Today, all too often, doctors take uncertainty as grounds for treatment, even aggressive therapy with high risks. ("When in doubt, take it out," as one surgeon told me.) This kind of medical activism isn't just a threat to our economic interests in controlling health care costs; it's also a misfortune for patients. As countless studies show, health care expenditures endup producing, in aggregate, disappointingly little improvement in health. "More" in health care is not better, if by "better" we mean a healthier society; health care can cost less and count more in beneficial impact, as shown by the record of other countries and by some health care organizations within the United States.

But how to create a more conservative practice style and, I might add, a more conservative style of health care management? A radical change in orientation will not spring up naturally, certainly not under the present system, which has richly

rewarded the opposite practices. It will not do simply to promote better research on health care outcomes or changes in malpractice law, neither of which will offer sufficient motivation to revamp basic procedures. Nor will it suffice to create regulatory programs, in either the public or private sectors, which look for the exceptional cases of gross inefficiency, since the crux of the problem is accepted, everyday decision-making.

Two strategies, whose advocates are often strongly opposed to each other, offer what I believe to be the best chance of inducing a change in health care decision making and a reduction in the rate of growth of health expenditures. One strategy calls for budgetary control from the center; the other for competitive organizations generating decentralized cost-sensitivity. But despite this difference, the two approaches have certain similarities. Since everyone else emphasizes the contrasts, let me stress what the two strategies have in common.

Both strategies involve the creation of effective countervailing forces against the health sector's internal tendencies toward expansion. The first—the strategy of global budget limitation—concentrates purchasing power either in a single payer or in a governmental body acting on behalf of payers to set comprehensive budgetary ceilings. We have long had a health care market dominated by sellers; this is an effort, in effect, to unify the buyers. The strategy seeks to impose hard budget constraints on the providers: lump-sum, global budgets for hospitals and fixed limits on total compensation available to physicians in a region. These budget constraints are intended to generate new decision-making environments, giving health care managers and professional peers incentives and leverage to bring more conservative practices and to match health care resources to needs. Such is the logic of global budget limitation.

The competitive strategy, while more decentralized, also seeks to create greater countervailing pressure against the providers and budget-constrained decision-making environments where managers and peers have the incentive and leverage to induce more conservative practices. In this model, the countervailing forces are health maintenance organizations and other managed care plans, driven by competition to match their resources to the needs of their populations. The key step here is the replacement of fee-for-service with capitation payment, which generates the functional equivalent of a global budget—indeed, a more global budget, since capitation payment yields a comprehensive budget cap on all services, not just on hospitals.

To be sure, the first strategy relies more on "government," the latter more on the "market." But such generalities are highly misleading because the first strategy uses "government" in a different way from current regulation, and the second calls for a different "market" from the one that currently exists. Because global budgetary limitation relies on limits on total expenditures, it can dispense with much of the failed micro-regulation of the health care system. Indeed, as many observers of comparative health policy have noted, countries such as Germany and Canada that use such budget limits actually have less micro-regulation of health care than do we in the U.S.

The strategy of health care competition, on the other hand, requires constructing a different kind of market—a system that Alain Enthoven has aptly characterized as "managed" competition—to overcome the legacy of past policies and to control the tendencies toward market failure of a free market in health care. To get groups of providers to compete against each other requires, not deregulating the market, but actively reconstructing and managing it—for example, to combat opportunistic behavior by health plans that try to keep costs low only by enrolling healthy subscribers. The strategy of competition does not, therefore, dispense with public authority, although the role of the authority here is more to maintain "fair play" among competitors than to allocate resources or budgets.

Both strategies, finally, are carried out most effectively within the framework of universal health insurance programs. Either budget limitation or health care competition is a recipe for greater social inequity—and quite likely will not work in practice—if we continue to exclude large parts of the population from coverage. No policy for controlling costs will be politically stable or widely attractive if it does not also answer the demand for health insurance security. Moreover, moving away from an insurance system based on employment is essential, not only because tying insurance to specific jobs inevitably produces gaps, discontinuities, and inequities in coverage, but because employers do not have the instruments—and generally do not have the knowledge or incentive—to exercise effective discipline over health care costs.

But which strategy to follow—overall budget limitation or health care competition?

The strategy of budget limitation has in its favor a proven record in other Western countries. That is precisely what some hold against it—the record is imperfect,

and the other countries are different from ours. The strategy of health care competition is distinctively American, with a base in existing prepaid plans in the U.S. And that is precisely what some hold against it—the record here is imperfect, and it is hard to see how it will work throughout our country, as in rural areas where the population is too dispersed to support competing health plans.

But we may not need one answer for the entire country. Rather, we ought to consider universal insurance proposals that give the states, and even regions within them, a structure to adjust the mix of competition and budget limitation. For example, a promising proposal put forward in February by John Garamendi, California's Insurance Commissioner, would create a "single sponsor" for health insurance in the various regions of the state. These "sponsors," which the Garamendi Plan calls Health Insurance Purchasing Corporations, would receive all employer and employee health insurance contributions and provide all citizens a menu of competing private health plans at varying prices (at least two of which in each region would be available at no extra cost). This is a unified system of health care competition on the model that Professor Enthoven has proposed. But, in some parts of the country, where the competitive model is either impractical or lacks support, the single sponsor could organize a single-payer system of insurance relying on global budgets for cost control.

Several national health insurance proposals before Congress, including S. 1446 (the "Health USA Act," introduced by Senator Kerrey) and S. 2513 (the "American Health Security Plan," introduced by Senator Daschle, Senator Wofford, and Senator Simon), provide both for national financing of universal health insurance and for the use of HMOs and other managed care plans by the states in carrying out their programs. These proposals would allow pluralism in the system, but they are not especially designed to foster competition. They also do not have any mechanism comparable to the Health Insurance purchasing Corporations of the Garamendi Plan—an active sponsor concerned with managing competition among alternative private plans. One great advantage of such a mechanism is that revenue need not be channeled through the Federal Treasury; the local earmarking of funds for health coverage may ease public suspicions that the required employer and employee contributions will disappear into a mysterious black hole in Washington! Moreover, the participation of private plans in the system will also ease fears of excessive concentration of power in government and reduce opposition from private industry, including large insurance companies.

With some modifications, the two Senate proposals I mentioned might provide a basis for giving the states several options in the design of comprehensive health reform. One such option would be to build choice of health plan into a framework of universal insurance that also includes various "upstream" controls on health care resources that should be regulated at the national level, such as training programs in the medical specialties.

This suggestion of combining the strategies of budgetary limitatation and health plan competition is now heresy to the advocates of each, and perhaps puzzling to many others. But if we are going to replace our current system of "unsurance," as my colleague Uwe Reinhardt calls it, with genuine security of coverage, we need a new framework that generates an internal logic to conserve health care spending. And that framework, I believe, can use elements from both strategies I have described and provide for experiment and adaptation in line with the great diversity across the United States.

RESPONSE OF DR. STARR TO A QUESTION SUBMITTED BY SENATOR WELLSTONE

Question. You commented favorably on citizenship-based systems of health care coverage. Would you please discuss the limitations of employment-based systems in controlling costs and creating universal access?

Answer. The existing employment-based insurance system suffers, it seems to me, from the following seven problems:

First, and most obviously, access to health insurance now depends on whether a member of the household is employed and what kind of employment that person has. part-time and seasonal work generally do not qualify for benefits. Children and spouses receive insurance only indirectly, incidentally, and haphazardly. In recent years, the limitations of employment-based coverage of children have become especially severe. Between 1977 and 1987 the proportion of children covered by employer-based coverage dropped from 72.8 percent to 62.9 percent. As of the summer of 1990, more than 25 million children—about 40 percent of all children—lacked employer-based coverage.

Second, the employee group is today the key unit (or "risk pool") for the spreading of health costs. Because of demographic differences among these groups, some peo-

ple receive relatively low insurance rates, while others face rates that are prohibitively high. Among the losers are those who work for small firms, or for firms with relatively older workers, or in occupations believed to create high health risks or to attract workers from high-risk groups.

Third, the system gives employers decision-making power over insurance and medical care. Under traditional insurance plans that allow the insured free choice of provider and impose few controls, the employer's power is a relatively minor concern. But the rise of health plans that more aggressively seek to control costs raises more serious questions: Should employers micro-manage the health care of their employee's families, or even select the plans that will manage that care?

Fourth, the tax subsidy of employer-provided insurance is much greater for higher-income than for lower-income Americans. The higher their income, the more likely Americans are to get insurance from their employer, the more generous are those benefits, and the more the tax subsidy is worth. The tax exclusion is a largely invisible federal program that provides subsidies in inverse relation to need; the people with the best insurance coverage get the most federal help to pay for it.

Fifth, employers and the plans they select have limited ability to control health care costs. Once investment decisions about health care have been made—creating a stock of hospital facilities, technological assets, and physicians—it is difficult for any buyer to cut costs dramatically below what the system typically generates. The chief effect of employers' cost containment efforts has been not to reduce costs, but to shift them—back to their employees and sometimes to other individuals with private insurance who have less clout in the marketplace.

Sixth, the employer-based insurance system generates extraordinarily high administrative costs. while Medicare's administrative costs run about 3 percent, private insurers absorb about 13 cents of every premium dollar in marketing and other administrative costs, taxes, and profits—a figure that does not include the administrative costs directly to the employer (or to the employee in filling out forms). The share of insurance premiums going to administration are especially high for medium size and small firms. For firms with fewer than fifty workers, insurance companies absorb about 25 cents of every premium dollar; for firms with five or fewer workers, insurers take 40 cents.

Seventh, employer-provided insurance has adverse effects on labor-management relations and employment, entangling employers in conflicts over health care, draining management time, and leading employers to make increasing use of uninsured part-time and contract employees, who enjoy few rights and little security.

Although some of the preceding problems may be partly alleviated by health insurance proposals like play-or-pay that build on the existing employment-based system, those proposals do not remedy all these difficulties. Indeed, there would continue to be gaps and inequities in coverage, great administrative waste, and problems in controlling costs.

It is time to devise a new system. As a Minnesotan, you are surely familiar with the with the varieties of capitation payment plans the need to fit those plans into the design of national health reform. If you put together a citizenship-based insurance system with a role for capitation plans—and you recognize the need to control opportunistic behavior by the plans—you will, I am confident, come up with a proposal similar to the Garamendi plan, even if "managed competition" is not what you had in mind.

PREPARED STATEMENT OF DEBORAH STEELMAN

In June, 1989, Secretary Sullivan appointed the Quadrennial Advisory Council on Social Security with a charge: to report on the financial security of American families, today and in the future.

It is my honor as Chairman of this statutory, private sector, all volunteer Council, to testify on our findings and recommendations. Serving with me on the Council were former government officials, consumers, health care providers, insurance, business, and labor leaders. Every geographic area of America and both political parties were represented, and our ages spanned six decades.

CHARTER OF THE COUNCIL

The work of the Council included a broader review than any previous Advisory Council on Social Security. The Secretary requested that we extend our study beyond the statutorily mandated review of Social Security and Medicare trust fund solvency to a broader examination of trends in our Nation's income security and health systems and their implications for the future financial security of American families. The Public Trustees, David Walker and Stan Ross, strongly supported this

course for our work. To fulfill the Secretary's charge, the Council designed an ambitious and unprecedented review of social security, savings and investment policy, pension policy, Medicare, Medicaid, direct health care, private insurance and other issues. Specifically, we looked at the financial ability of the current Social Security, Medicare, and Medicaid programs to meet today's demands in income security and health care. We examined the ability of these same programs to continue serving future populations, including the "baby boom" generation—the largest generation of retirees our country has ever experienced. We also projected the ability of our economy to support these programs into the future, and their impact on our economy.

CURRENT HEALTH CARE STRUCTURE UNSUSTAINABLE

To begin, let me share with you some of the information contained in our study, *Income Security and Health Care: Economic Implications 1991–2020.* We convened an expert panel, consisting of 15 preeminent actuaries and healthcare experts, and asked them to review the current economic conditions of our income security systems and our health care financing systems. In light of certain factors, they projected the economics of these programs through the year 2020.

The report indicates that public expenditures for health care and income security will continue to rise as a percentage of the federal budget and as a percentage of taxable payroll. In the year 1990, Medicare and Social Security cost the equivalent of 15 percent of the taxable payroll of the United States. Under the same projections that produced the previous chart, Medicare and Social Security would cost the equivalent of 32 percent of taxable payroll.

This increased public responsibility will be born by a smaller portion of workers—the baby boom's children. Because the elderly as a group are growing faster than workers, there will be fewer and fewer workers to support our public programs. The worker/dependency ratio will drop from 3.4% today to 2.4% in 2020.

However, our income security systems appear relatively sound, including Social Security, which is fiscally solvent well into the future. We also reviewed other sources of income that seniors rely on: pensions, savings, and earnings. We found that there are vulnerable seniors, especially women living alone over the age of 85. Nevertheless, we found that seniors as a group are better off today than are workers. We also found that seniors will continue to be better off than workers—even when the "baby boom" generation retires.

Instead, we found that it is the health care system that threatens to erode the income and quality of life of our senior citizens and workers. The picture for health care is grim. Therefore, the Council concluded that our report should focus squarely on health care reform. If we do not reform the way we use, deliver and finance health care, the serious potential exists to disrupt our quality of life, our standard of living, and our economy. That is the simple, urgent message of the 1991 Advisory Council on Social Security Council. Without reform of our health care system, the long term financial security of all American families is at risk.

Today, health care consumes almost 12 percent of our GDP and is growing two to three times the rate of general inflation. Real health care costs are increasing four times as fast as real wages. If health care costs grow at the rate they have over the last twenty years, it will consume 31.5 percent of our GDP in the year 2020. This projection is quite conservative.

NECESSARY CHANGE IS OF UNPRECEDENTED POLITICAL MAGNITUDE

This projection should not and will not come true. If one dollar out of every three is spent on health care, it would mean the debilitation of our economy and the bankruptcy of our nation. Therefore, the most important observation about these projections is the magnitude of the changes we must undergo to reduce health care costs. We have rarely, if ever, accomplished through our legislative process change of such magnitude. Change of this size cannot be accomplished without strong and sustained public support.

This Council, therefore, undertook an unprecedented review of the public's understanding and opinion about health care. We held 15 public hearings where we listened to Americans' concerns about health care—almost 1200 people talked to us. We conducted 73 site visits in rural, suburban, and urban locations. In addition, we conducted a public survey to help quantify what we had learned at these public hearings.

PUBLIC PREFERENCE NECESSARY TO ENACT AND SUSTAIN CHANGE

In our site visits, we found an overwhelming range of contradictory opinions about our health care system and Americans' desire for reform. What was the "right or best" reform for one person or group was "abhorrent and unacceptable" to another.

We heard frequently that reform was fine for the other guy—those that don't have adequate access or financial resources. Just don't change my system, restrict my choice, or increase my costs. The American people said loud and clear that they want us to maintain our standards in providing them continued access to the best medicine, the best doctors, and the best health care of any nation on earth.

But they also sent the message that we must reduce the unbearable costs of our system. The American people desire change, but our hearings and our survey shows no clear preference for any specific type of comprehensive reform. In fact, the Council's public survey found that while 63% of Americans favor national health insurance, as often reported, 67% favor a reform based on managed care; 59% favor employer mandates; 71% favor a universal plan that would protect only against high costs; and 65% favor an individual tax credit.

In other words, Americans are not necessarily ideological about health care. They do want change, but they haven't heard anything more than statements about "let's go to national health insurance" or "let's do something drastic." Americans want to know more before they pledge solid support for any idea.

The challenge the Council faced was to find a way to best involve the American people in the search for the right comprehensive reform. Americans must contend with the conflict inherent in reducing costs, in their love of technology and their impatience with waiting lines, their freedom to choose their own doctor, and make their own choices about their care.

"SHOW ME"

Where do we start? The proposals for reform have proliferated as the public spotlight on health care reform has intensified. Many experts feel they have solved the problem of the ultimate design.

The Council recommendations stress that the notion of "the ultimate design" is just that, a design theory that may or may not work, and that currently holds no particular majority of support among the American people. Perhaps because I hail from Missouri, I have a special affinity for the "show me" insistence that resides in all Americans. We want to know how change will affect our own health care. Will it work? Will it accomplish what I want it to? Will it hurt me or my family? How will it help me or my family? What changes will I experience?

The Council recommended a process by which we could judge each plan on experience, not what simply "sounds right" or "might work." The Council identified five criteria that we believe any plan should meet:

1. **Every American must have access to health care, not just access to health insurance, but access to care.** An insurance card is inadequate support for many segments of our population. Many different kinds of services, including home and long term care, rehabilitation, and community services, must be considered, not just preventive and acute care services.
2. **Health care costs in the long-term must be significantly reduced.** As stated by Jeremy D. Rosner for the Progressive Policy Institute, "[The] disagreement over the best ways to control costs is nourished by the lack of data on each approach." We simply do not know what mechanism will be result in the most significant cost reduction. Theories should be put through the fire of experience. Certain techniques may work better in certain areas of the country; the heavily regulated health care markets of the northeast will respond differently than market-oriented health care systems of the south and west.
3. **Implementing reform cannot cause serious disruption in the workforce.** Health care currently forces inappropriate decisions in the workplace today; job lock is just one example. Reform must repair these inequities and should not cause others, such as locking certain employment sectors into one type of coverage, or substantial job loss or job dislocation.
4. **Reform should have a net positive effect on the general economy.** The health sector has produced more jobs in the last decade than any other, and it is one of our economy's most rapidly growing export sectors. Cost reduction that results in net loss of employment is counterproductive and unacceptable.
5. **Health care reform must be consistent with American culture and values.** We must develop a system that meets with our concepts of freedom and rights for individuals. Comprehensive health care reform will require strong and sustained public support.

THE ACSS APPROACH: TEST COMPREHENSIVE REFORM AND MOVE NOW ON CONSENSUS REFORMS

The Council recommends two simultaneous levels of reform to achieve immediate action:

1. Begin experimenting with a range of comprehensive reforms at the state level; and
2. Enact consensus federal reforms now to improve access and reduce costs.

This double-barreled approach would cost approximately $2 billion in its first year and $6.8 in the second. Yet this proposal would go farther faster to actually help people now. The proposal provides universal access to care for all children and would actually make services available to 20 million of the uninsured.

Neither the prototypes, nor our access and cost proposals, interfere with the larger political debate on health care reform. On the contrary, they will in fact support and improve the public debate. They will build the necessary foundation for future broad-scale systemic changes, change of such a magnitude that no quick fix or single season of political debates can accomplish it.

"COMPREHENSIVE" REFORM: NOT JUST FINANCING

The Council defined comprehensive reform in an important way. We believe that simply changing the way providers are paid is insufficient to address the complex issues contributing to our access and cost problems. Most of today's debate on so-called "comprehensive reforms" centers only on how we pay providers, a subset of the financing reform issues.

Such a limited view of comprehensive reform will result in yet another "piecemeal" approach of the variety that has built the system we currently suffer. Finance reform will not eliminate AIDS (medical costs estimated to be $5–13 billion by 1992), tobacco-related illnesses (medical costs in 1990: $22 billion), gunshot wounds (medical costs in 1991: over $4 billion); drug and alcohol-related costs (medical costs in 1990: approximately $180 billion), low-birthweight babies (medical costs in 1990: $2.6 billion), or illness caused by poor nutrition (for example, cost in 1990 for coronary bypass surgery: $8.5 billion; cost for treatment and rehabilitation from strokes in 1990: $13.2 billion).

Financing reform alone cannot prepare us for the changes in the ways our society will age, and the types of care we will need, especially the dramatic increase in the need for home care and long term care. As noted by David Osborne and Ted Gaebler in *Reinventing Government:*

> Our health care system was set up to deal with acute care: life threatening illnesses and injuries. It was so effective that today most people die of chronic, degenerative problems—of "old age." Yet we continue to respond with an acute care system of high-technology hospitals and highly trained doctors. Ironically, it was our very success at acute, professional care that left us with an elderly population desperate for something more.

Comparisons are often made between the per capita costs of the Canadian system and the per capita costs of our own. This statistic is often cited as a reason to adopt Canada's provider payment system. Yet, the pathology of Canada differs markedly from the pathology of the United States. In fact, if we eliminated violence, drug and alcohol abuse, AIDs and crack-addiction among newborns, the United States would spend about the same on health care—costs as Canada. Why aren't we spending as much time debating these approaches to address these issues which would benefit individuals and society far more than simply the reduction of health care costs, as much as we debate rate regulation?

Financing reform alone will not address the multiple causes of what we know is an unsustainable system, yet we continue to focus our energies here almost exclusively. As the Progressive Policy Institute observed in its February 1992 paper, "A Progressive Perspective on Health Care Reform":

> The health care debate now focuses almost entirely on financial matters. But health costs and outcomes are significantly shaped by individual responsibility, corporate habits, community initiative, and cultural norms within the medical professions. Conservatives often cite such factors as individual unhealthy behaviors as an excuse for not pursuing national reforms; liberals underemphasize these factors out of fear of sounding conservative. Both sides would benefit from actually doing something about these non-financial factors, and making them a central part of their health care agendas.

The Council believes that reform cannot be considered comprehensive without addressing all of the major elements in health care reform: the role of the individual in the use and financing of health care; our health care delivery system, and our health care financing system.

STATE-FEDERAL PARTNERSHIP FOR COMPREHENSIVE REFORM

The Council recommends investing $3 billion in new Federal dollars for state experimentation. The Federal government would solicit states or community initiatives on a specific number of comprehensive reforms. Ideally, we would see every major idea—single and all-payer systems, individual mandates, managed competition—implemented on a major scale within one year of receiving appropriations. That is faster than any phase-in of any major proposal under consideration today, most of which require 3–5 years to phase in upon enactment.

Comprehensive reform at the state level would provide two essential elements to today's debate: public support and knowledge.

This Federal leadership would result in covering millions of people while providing the opportunity to see how well costs are reduced. People could see how each plan measured up, for themselves, for the country. We recommend a strategic and aggressive initiative, conducted under Federal leadership, to work with states to ensure that we make the right decision, one that can last the next thirty years, one that changes our health care system for the better, not for the worse.

To any critic who decries this process as unnecessary, I challenge them to find a current proposal which would get faster results, holds the promise for greater political consensus, and would not cause great economic and workplace disruptions. We can start now to implement these reforms and quickly begin to understand how they would work, what flaws are in their design, what people do and do not like.

The Progressive Policy Institute states that "the lack of certainty over the best approach to cost control argues for state-level experimentation." In fact, state enactment of comprehensive reform is happening at an unprecedented pace. Oregon, Minnesota, Vermont and Florida have been some of the first to enact major changes.

OREGON reform provides improved coverage and rations healthcare by ranking the costs and benefits of all services. The plan extends Medicaid coverage to all Oregonians living below federal poverty level; appoints the Health Services Commission to prioritize health services through a public process and an evaluation of "effective and appropriate care extends a Standard Benefit Package of care which is defined by the prioritized list and the state budget process, to all Oregonians whether covered by Medicaid or through private insurance; requires all employers to provide at least the Standard Benefit Package to all permanent employees and their dependents; establishes a high-risk pool to cover those denied insurance due to preexisting medical conditions. The plan reduces the level of services covered under Medicaid. The state Medicaid program would not pay for medical treatments that rank below 587 on a list of 709 medical procedures, including the treatment of viral pneumonia, chronic bronchitis, and some common medically necessary pediatric services.

MINNESOTA enacted HealthRight, a health care reform bill which calls for expanded state-run children's Health Plan to include in-patient services for low-income, uninsured children and their families; state-subsidized health insurance coverage available on a voluntary basis to uninsured Minnesotans who are not eligible for Medicaid and have incomes less than 275% of the national poverty level; small group reforms permit rating for experience, age, and geography within acceptable rate bands; specific funding mechanism (tax paid by doctors, pharmacies, drug wholesalers, hospitals, and drug manufacturers who sell directly to the state, tax on cigarettes and tax on health-care providers); benefit package for small business to include prescription drug coverage; and establishes a commission to review expenses, new technology, services, and high-cost pharmaceuticals, and any provider with an expense exceeding $500,000 must notify the Commissioner of Health, and a panel reviews the expense for clinical and cost effectiveness, and improvement in health-care outcomes. It does not include employer or individual mandates, or artificial caps on insurance rates.

VERMONT enacted a health care plan that would guarantee health care for all Vermonters by 1995. The bill creates a three-member Health Care Authority, consolidating the functions of several state agencies, to establish a common benefit plan, set minimum standards for health insurance, and by 1994, to develop two options for universal access; creates a single insurance pool; prohibits "cherry picking" by insurers; immediately sets aside funds for health care for low to middle income children; proposes the creation of at least four new family practice residency slots within two years at the University of Vermont; and protects insurance companies from financial losses due to rating restrictions based on a persons age and health.

FLORIDA created a new Agency For Health Care Administration to carry out regulatory functions such as faculty and professional licensure and hospital budget review. The law creates a two phase approach, a voluntary program providing all residents with access to an affordable basic benefit package and develops a reinsur-

ance pool for carriers and marketing standards, promotes the availability of insurance to firms of 3–25 employees, adopts general insurance reforms governing exclusive and preferred provider organizations, dependent coverage, portability of coverage, conversion policies, supplemental Medicare insurance, long-term care insurance, and minimum standards for disability. The second phase is a state-run program which would be implemented in the event that the voluntary program is ineffective. The law also addresses medical practice parameters, and the need for medical, nursing, and dental students to work in underserved areas.

MOVE NOW ON CONSENSUS REFORMS

Even as the states move forward with innovative approaches to comprehensive reform, it is unnecessary and unacceptable to delay federal enactment of certain consensus reforms, including insurance reform and medical liability reform, and measures to improve access to care in communities throughout the nation.

Our cost reduction proposals focus on the cost drivers in hospitals, insurance, doctors offices, and lawyers.

1. Lawyers: enact a stringent federal medical liability reform law;

2. Doctors: change the practice of medicine through removing incentives to overprescribe; reform medical education to include cost effectiveness information; publishing fees with quality data; and establish a national registry for health care proxies and living wills to enable the physician to better act upon the patient's wishes.

3. Insurance: enact small market reform, reduce administrative costs by requiring uniform claim forms and electronic claim submissions; and reforming the rules to restore fairness to the small insurance market;

4. Hospitals: eliminate or modify unnecessary hospital beds by changing antitrust rules that discourage hospital mergers and joint ventures; and encourage electronic patient record-keeping; selective contracting in the private and public sector; establish Centers of Excellence for complex high risk procedures, develop a national process for technology assessment, maintaining incentives for cost reducing innovation and discouraging cost increasing innovation; research to improve our knowledge of the biomedical and behavioral issues important to an aging society, including the relationship between health care financing and service delivery.

Our proposals to expand access are powerful. We recommend investing $3 billion in new federal dollars through five initiatives:

1. Expansion of school area clinics for children from birth through elementary school. We recommend school-based insurance for children and young adults up to age 22. Both programs would be subsidized for those below 185% of the poverty line, and both would be voluntary for all parents.

2. Coordinated efforts to prevent infant mortality.

3. Improved access to health care by increasing the number of community health centers by 250, bringing the total federally sponsored community health centers to over 800, and we recommend increasing the doctors and other health professionals in rural areas and inner cities through doubling the budget and redirecting the priorities of the National Health Service Corps. We propose initiatives to improve emergency services in rural areas. Finally, we recommend federal legislation to reform the insurance market for small employers of 50 or fewer employees to preempt state benefit and anti-managed care laws and replace them with federal standards.

4. Insurance reform to ensure that anyone changing jobs will suffer neither preexisting condition nor exclusion clauses, and to prevent price spikes and other marketing practices that make insurance costs unpredictable and unaffordable.

These recommendations provide a framework for the future: combined, they provide access to care for 20 million uninsured Americans, they reduce costs now in areas we know savings can be achieved, and they provide us a roadmap to achieve comprehensive reform on the fastest track possible.

The road to success in health care reform must be paved with strong public support, sound ideas, impeccable results and a great dose of common sense. This Council struggled to find that combination.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

The American Association for Respiratory Care (AARC), a 33,000 member professional association of respiratory care practitioners from across the country, shares the growing concern of our colleagues within the health care community over the direction of U.S. health care policy. Inadequate access to care and the spiraling cost of providing health care creates a growing urgency to restructure the current health care system. The laborious debates on the future of this country's health care policy have already begun in Congress. The decisions which must be made will not be easy or painless. The AARC believes that any viable reform package must incorporate three major elements:

(1) **Universal Access.**—Any plan must result in the development of a system that assures all Americans, regardless of age, income, employment setting, or health status, access to quality, cost-effective, and comprehensive health care. The majority of Americans have an employer-based health insurance program. This system is fraught with inequities. This system leaves 35 million Americans, 10 million of whom are children, without health care coverage. The system relies upon the willingness and financial ability of employers to provide insurance. We must strive to implement a system, whether employer-based or single payor-based, which provides the same opportunities for all citizens to receive adequate health care when needed.

(2) **Delivery Site Neutrality.**—Current policies and procedures have been slow to recognize the more appropriate and less costly sites of care. Inpatient hospital care has been shown to utilize the most resources of all health care delivery sites. While appropriate care could be rendered in the home, nursing home, or outpatient setting, federal laws and regulations often do not permit any change of venue. This rigidity has resulted in fragmented and often inconsistent payment policies across various facilities and settings. The health care system must retain the flexibility to adapt as medical technology advances to providing needed services in the most appropriate care settings.

(3) **Cost Containment.**—Incentives for cost efficiency must be an integral component of reform. Inappropriate cost shifting to other sectors of the health system must be avoided. Outcomes research, practice guidelines, technology assessment, and managed care must all be a part of any reform effort.

We believe the above components of reform must be offered together to truly implement a comprehensive and cohesive retooling of the current health care system. Many faults of the current system arose out of incremental, albeit well-intended, changes to amendments in health care policies. A piecemeal approach to health care reform will simply perpetuate the current inequities of the system.

As Congress begins to address these enormous reform challenges, we urge members to recognize the importance of home care services as an integral part of the health care delivery system. Home care services have proven to be a cost-effective alternative to expensive acute care hospital stays. As the population ages, as the spread of AIDS continues, and as medical advances allowing technology-dependent patients to lead more productive lives outside the hospital, the need for respiratory care services and the professionals who are trained and educated to provide the care will increase. Because respiratory patients will continue to be discharged from the hospital still requiring care, respiratory services will increasingly be in demand in the alternate care site. Overall, government health care policy has not kept pace with the advancement of medical technology. In particular, this has been the case for respiratory care services. When the Medicare/Medicaid program was first developed, respiratory care was fully recognized as a viable component of hospital services. Coverage and reimbursement for this service in the hospital has never been in question. However, in terms of the coverage for respiratory care services rendered

outside the acute care institution. Medicare/Medicaid policy has barely advanced in the past 20 years. The scope of respiratory care services has developed significantly beyond those services that can be delivered only in the hospital setting. Where respiratory patients were once confined to a hospital bed, the same patients may now be cared for in a skilled nursing facility or the patient's own home. As national health reform is debated and structured, it is the respiratory community's recommendation that Congress should recognize the role that respiratory care plays in the provision of cost-effective health care in the alternate site. There is a preponderance of evidence on the cost-effectiveness and treatment efficacy of rendering respiratory care in alternate care sites. The studies documenting cost effectiveness of respiratory care have varied in methodology, scope, and time frame. The conclusion is still the same: home respiratory care saves money.

- In the early 1980s, the Department of Health, Education and Welfare sponsored a study that tracked 775 chronic obstructive pulmonary disease (COPD) patients (i.e. those suffering from a degenerative disease of the lungs), who received respiratory services from a qualified respiratory therapist. The results of the study showed that hospital readmissions for these patients were reduced from 1.28 per year to .55 per year. Furthermore, for those patients who were re-admitted to the hospital, the length of stay was decreased from 18.2 days to 5.7 days. The study estimated the savings for these 775 patients totaled $1,097,250 (1980 dollars).
- A 1991 economic analysis of home medical equipment services was recently completed by the firm Lewin/ICF. The study focused on how the availability of home medical equipment services affected the cost of care for patients in three separate diagnostic categories. One of the categories studied was patients suffering from COPD. Lewin/ICF determined that $520 per patient per episode could be saved if a COPD patient was to receive care in the home rather than in the hospital. With an estimated patient population of 93,000 COPD patients per year, savings to the health care system amounts to over $48 million per year.
- A recent Gallup survey studied the cost of providing hospital care to chronic ventilator patients. By survey estimates, there are over 11,500 chronic ventilator patients currently in U.S. hospitals costing an estimated $789 per patient per day. Gallup calculated that $9 million was being spent daily by hospitals for the care of these ventilator dependent patients. Once a patient is medically able to be discharged, it takes an average of 35 days to place a chronic ventilator dependent patient in an alternate care site such as the home or skilled nursing facility. That translates to an excess of $27,000 per patient in unnecessary hospital costs. Outdated reimbursement policies which limit the patient's access to respiratory care services outside the hospital are to blame for the discharge delays.
- A 1989 consensus conference co-sponsored by the AARC, the Food and Drug Administration, and the Health Resource Services Administration, which was attended by over 60 national organizations and associations, studied the problems associated with the introduction of respiratory care equipment into the home. One important recommendation from the consensus meeting called for modification by third-party reimbursement policies to allow homebound respiratory patients to receive, when necessary, care from respiratory professionals.

As members of Congress debate the various health reform initiatives, we urge them to recognize the importance of allowing patients in need of respiratory care services access to the care in the most cost-effective setting and provided by professionals who are formally trained and educated in the field of respiratory care.

The current focus on the issue of health care reform in America provides the policy-makers of this country a unique opportunity to reshape the health care system as it enters the 21st century.

Statement of the American Orthotic and Prosthetic Association

I. Introduction

The American Orthotic and Prosthetic Association (AOPA) is the national membership organization representing the approximately 1,300 facilities that provide orthotic and prosthetic (O&P) patient services to the physically challenged throughout the United States. Practitioners employed by AOPA members design and fit orthoses (braces) and prostheses (artificial limbs) that enable these physically challenged individuals to overcome often serious and crippling injuries and return to

productive lives. AOPA appreciates this opportunity to comment on the important issue of health care reform in this country.

II. ORTHOTICS AND PROSTHETICS (O&P) AND DURABLE MEDICAL EQUIPMENT (DME) ARE DIFFERENT AND DISTINCT DISCIPLINES

In the past, confusion over the differences between O&P and DME has caused policymakers in the Congress to inadvertently consider action which dramatically affects the O&P industry and profession due to discrepancies in how O&P is defined. While "orthotics" and "prosthetics" has been broadly defined by Congress to include a number of items not typically utilized in an O&P practice or items considered to be "DME" by the O&P field, "orthotics" is strictly defined by the O&P field as "orthoses or braces" and "prosthetics" is strictly defined as "artificial limbs."

The wide differences between O&P and DME were recognized by Congress in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). Section 4153(a)(1) provides for the creation of a separate statutory section, 42 U.S.C. Section 1395m(h), that pertains only to O&P and moves the O&P reimbursement provisions out of the section that addresses DME. This statutory separation allows Congress to consider O&P in its own right and underlines the impropriety of treating and evaluating O&P and DME in the same manner.

It is the foremost request of the O&P field that O&P be treated and evaluated separately from DME relative to any health care reform initiative implemented by Congress.

III. COVERAGE OF O&P SHOULD BE INCLUDED IN ANY BASIC BENEFITS PACKAGE

The goal of the orthotic and prosthetic (O&P) field is to restore patients to their optimum level of function, thereby reducing dependency and enabling the patient to remain a productive, economically independent member of society.

The O&P field recommends that any legislation designed to reform the current health care system should recognize O&P as an essential ingredient of any basic health care benefits package and should incorporate the following principles:

- *Universal Access to Care*—All American citizens, regardless of age, income, disability or employment must have access to a basic benefits package which includes appropriate, affordable, quality O&P health care services.
- *Comprehensive Health Care Services*—Health care reform should insure the availability of a full range of services, including O&P, necessary to provide a continuum of quality health care, and should provide access to all needed services in the most appropriate settings. A basic benefits package must provide a beneficiary with the appropriate O&P device and all related professional services, and must be made available in the most accessable hospital or community-based settings.
- *Quality Health Care Services*—Health care reform should require that all rehabilitation service providers and health care facilities be accreditated or certified by a recognized accreditation/certification body and/or in compliance with relevant state licensing or other regulatory requirements.

The O&P field strongly supports the implementation of measures that would promote the quality control of healthcare services provided to beneficiaries and urges Congress to subject all providers of services, including O&P, to certification to assure a consistent level of quality care. Although O&P practitioners provide healthcare services for which they are highly trained and subject to certification, there are no national certification requirements for the provision of O&P services. We oppose any proposal to prohibit certification by private agencies, and take this opportunity to draw your attention to a study done by the Institute of Medicine, *Allied Health Services—Avoiding Crises,* which concludes that certification by private agencies is far preferable to licensure by state agencies, since it assures most of the benefits of licensure at a fraction of the cost.

- *Consistency in Coverage/Cost-Effectiveness*—Consistency in coverage of decisions for O&P devices, operational efficiency and cost-effectiveness should be primary goals of health care reform.

IV. COVERAGE AND REVIEW CRITERIA

The O&P field supports the development of coverage and review criteria and stands willing to work with Congress to establish a uniform national coverage and utilization review criteria as they relate to O&P.

V. COMPETITIVE BIDDING

While the concept of competitive bidding may lend itself well to the purchase of ordinary manufactured products, it is inappropriate for the purchase of customized devices and high quality health care services O&P services involve the activity of a highly-trained, certified health care practitioner who provides the patient with the proper individually custom-fabricated orthosis (brace) or prosthesis (artificial limb). In addition, the orthotist or prosthetist is responsible for instructing the patient how to properly use the orthotic or prosthetic device and must often work with the individual patient during the course of his or her disability or rehabilitation over an extended period of time, oftentimes for a lifetime.

The fact that these highly individualized O&P health care services are so inextricably tied to O&P devices that are customized to suit the needs of only one individual makes competitive bidding inappropriate for the O&P industry. To impose a competitive bidding system on the O&P industry would, in effect, reward the O&P practitioner for reducing the quality of health care services and delivering a marginal product.

VI. MANDATORY ASSIGNMENT

The O&P field is unequivocally opposed to the concept of mandatory assignment. The imposition of mandatory assignment requirements on O&P practitioners would effectively threaten the overall quality of care for O&P patients and limit access to O&P health care services.

Access to quality O&P services would be threatened, particularly in rural areas, because the absence of balance billing would make operation of a financially marginal facility problematical. The overall quality of care of all beneficiaries would be adversely affected because the practitioner would have to treat more patients to recoup the costs of running a facility. In addition, the patient would be forced to find another O&P practitioner in those cases where it would be economically unfeasible for the current practitioner to provide services.

VII. STANDARD HEALTH INSURANCE CARDS/ELECTRONIC BILLING AND VERIFICATION SYSTEMS

The O&P field supports, in general, the implementation of any measures that would serve to facilitate billing and claims processing and reduce unnecessary paperwork. The ability to conduct eligibility verification, billing, claims adjudication, and payment electronically through the use of standard health insurance cards by all insurers and payers would effectively eliminate the confusion and paperwork associated with these procedures. The standardization of electronic billing systems, including bill formats and standard coding of diagnoses and procedures, would result in new claims processing proficiencies and would enable the O&P practitioner to provide quality health care by focusing on the patient rather than the billing process. The O&P field also supports, in general, the utilization of technology that would facilitate the ability of providers to verify eligibility and benefits by electronic means and recognizes the advantages of using electronic funds transfer technology as a means of expediting the payment process.

However, while we support the utilization of existing technology to achieve efficiency of operations, it is the unfortunate fact that a majority of O&P providers do not have access to this technology at present. With the exception of a small number of member companies, the majority of O&P facilities can be characterized as "Mom and Pop" operations. These operations oftentimes do not have the means or the sophistication to take advantage of some of the existing technology. It is, therefore, the position of the O&P field that any health care reform package should not make the use of this technology mandatory in order to protect those small businesses that are economically fragile.

VIII. CONCLUSION

The O&P field urges Congress to treat and evaluate O&P separately from DME in considering the various health care reform proposals before it and takes the position that coverage of O&P healthcare services should be included in any basic benefits package. We support efforts to provide all Americans with access to appropriate, affordable, quality health care services and stand willing to work with the Congress to help achieve this goal, particularly as it relates to O&P.

AMERICAN SUBCONTRACTORS ASSOCIATION, INC.,
Alexandria, VA, May 29, 1992.

Hon. BOB PACKWOOD,
Ranking Minority Member,
Committee on Finance,
U.S. Senate,
Washington, DC.

Dear Senator Packwood: The American Subcontractors Association (ASA) would like to express its strong commitment to reform of our current health care system. Although many proposals have been introduced in Congress, little action has been taken thus far to seriously address the issue of reform.

The American Subcontractors Association is a national trade association with more than 7,000 member firms representing all major construction trades in 72 chapters nationwide. ASA is the only national organization that speaks exclusively for the interests of union and non-union construction subcontractors, regardless of trade specialty.

Earlier this year, the ASA Board of Directors met to discuss possible health care reform options. ASA would like to inform you about the health care initiatives that were approved by our members.

ASA members feel that it is imperative that our first goal must be to reduce the current cost of health care. ASA suggests that the first step toward cost reduction be legislative reform of the civil justice system with respect to medical malpractice. Escalating costs of malpractice settlements are being directly shifted to the consumer, thus making medical care unaffordable for the majority of Americans.

Secondly, ASA strongly advocates the development and implementation of standardized claims and data forms. Administrative costs would be substantially reduced and the savings could be passed along to the consumer.

In addition to cost reduction, ASA recommends several initiatives to better enable the consumer to retain health insurance. An increase in the tax deduction for the cost of providing health insurance for the self-employed would make health insurance more affordable. This savings would give the self-employed an incentive to provide health insurance, while also easing the financial burden associated with maintaining a health insurance program.

ASA supports legislation to establish a program of voluntary federal certification of managed-care programs and of utilization review programs. These programs would place a more effective system of checks and balances on the propriety of medical services provided to a patient.

Finally, ASA recommends that legislation be enacted to prohibit insurers from denying coverage on the basis of pre-existing conditions. Further, ASA believes legislation should be enacted to restrict variations in premiums for small employers to factors such as health status, claims experience, length of time since the policy was first issued, industry, or occupation. Small employers are finding it increasingly difficult to absorb the increased costs of health insurance for employees and these initiatives would be a step in the right direction.

The American Subcontractors Association urges the Committee (Subcommittee) to seriously address the issue of health care reform during this session of Congress. In so doing, it is ASA's hope that you will keep in mind the options I have outlined in this letter. Instead of increasing the burdens on businesses and other consumers, cost reduction is the most critical element to making health care more affordable for everyone.

ASA thanks you in advance for your efforts and sincerely appreciates any positive action you may take in this regard.

Sincerely,

WAYNE T. RUTH, *Chairman, Government Relations Committee, American Subcontractors Association.*

STATEMENT OF THE HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

The Health Industry Manufacturers Association (HIMA) appreciates the opportunity to submit this testimony to discuss HIMA's perspective on a comprehensive revision of America's health care system. HIMA is a national trade association representing nearly 300 companies that manufacture medical devices, diagnostic products, and health care information systems. HIMA companies' sales represent more than 90% of the domestic market.

HIMA supports a market-based approach to system-wide health care reform that will expand access to care, reduce costs, and maintain the high quality of health care Americans have come to expect. We believe that the American health care delivery system is the best in the world. Any reforms should build on this existing solid foundation, and individual choice should be the principal mechanism for determining medical expenditures, utilization of health care services, and resource allocation.

More specifically, HIMA believes that:

- Insurers and providers should be encouraged to develop, and employers and public assistance programs to make available, a wider choice of health care plans that more adequately fit the needs of consumers.
- Costs should be moderated thorough market-type incentives that encourage rational utilization and cost-effective delivery of health care services.
- The public and private sectors should be encouraged to provide access to health care through various insurance approaches.

HIMA has not proposed or endorsed any global health care reform proposal. We claim no special expertise in many of the insurance and tax laws that are involved in formulating a comprehensive plan. HIMA is using the principles we mentioned earlier to evaluate all of these proposals, and 'we will continue to monitor them closely.

However, HIMA companies do have extensive expertise in the development and use of medical technology. We are committed to using this expertise to fashion strategies that will reduce costs without compromising quality of care. We will tailor these ideas to fit within the framework of any major health care reform plan that is considered by Congress.

One issue that has attracted a good deal of attention is the cost of administration and overhead for hospitals, doctors, and patients. Our industry is especially well qualified to discuss this question because a number of our companies specialize in the development and production of health care information systems—both software and hardware.

HIMA believes that properly designed and managed administrative simplification would improve patient care and reduce costs. Before we explain our position on the most effective way to implement administrative reforms, we would like to provide some background about the administrative costs of health care in our system today.

Observers of all persuasions have noted that the administrative costs of the U.S. health care system are far in excess of those of virtually any other system. In a 1987 study published in the New England Journal of Medicine, U.S. administrative costs comprised 24.1% of total health care costs; in Canada, administrative costs were only 11.1%. At the current annual U.S. expenditure level of about $700 billion, the difference in these two administrative percentages aggregates to over $90 billion annually. It is obvious that any reduction in administrative costs which allows dollars to be returned to direct patient care will be beneficial.

A number of bills have been introduced in this Congress that emphasize methods for improved manipulation of payment, fiscal, and administrative data. This focus underscores a fundamental, yet often under-appreciated fact concerning health care: *health care is an information industry.* Most health care providers spend the majority of their time creating or using information. Only a small percentage of this information is then abstracted and used for submission to payors, reviewers, and other agencies.

Unfortunately, although it is an information industry, health care lags behind virtually every other information industry in its level of expenditures on information support and in its use of automation to improve efficiency, efficacy, and quality. While most other information system industries spend from 5–10% of their operating budgets on information systems, health care institutions typically spend only one to two percent, leaving the bulk of the repetitive and error-prone clerical work to be performed manually, often by highly compensated professionals.

The health care information systems suppliers that are members of HIMA provide services and systems for clinical, administrative, and financial processing to many of the hospitals and physicians in the United States. Most HIMA HIS members have been actively involved for some time in the very efforts which are now being studied by this Committee.

HIMA is also a sponsor of the Health Industry Business Communications Council (HIBCC), a consortium representing health care business partners. HIBCC was founded by HIMA, the American Hospital Association, the Health Industry Distributors Association, the Pharmaceutical Manufacturers Association, and the National Wholesale Druggists Association. The primary charter of the Health Industry Business Communications Council is to facilitate standardized communications among

participants in health care delivery: manufacturers, distributors, providers, and payors.

Now, we would like to share our perspectives about the most efficient way to use health care data. HIMA believes that a uniform data set should be adopted that eventually includes all relevant patient data. Although the optimum data set does not currently exist, that should not prevent the immediate use of a very good data base that can be steadily improved.

There are a number of data sets that could be used now as a legitimate starting point. For example, the Health Care Financing Administration's (HCFA) Uniform Clinical Data Set (UCDS). This 1600 element set is not perfect, but it is very good. And it is much more important to start with one carefully constructed data set than to wait until the ideal has been developed.

In order to provide one more opportunity for input, the selected set should be noticed for public comment for a reasonable period before the Secretary of Health and Human Services (HHS) promulgates it. The final modified set should be the only data that providers are required to maintain. All the information requested by payors, reviewers, and other agencies would come from this set.

The designated data set should be updated annually to accommodate new information that clinicians, providers, and carriers can justify adding. The goal should be to eventually have all relevant health care data in the system.

The use of a uniform data set would lead to savings from systems used to determine the adequacy, appropriateness, and sufficiency of services such as utilization review, quality assurance, and other concurrent and post treatment analyses. These procedures are a major focus for both providers and payors, and are a key to both the cost and the quality of care. Examination of the administrative overhead invested in assuring these parameters reveals a large number of additional areas where costs can be reduced or eliminated.

About one-third of a physician's time and almost one-half of a nurse's time is spent doing clerical/administrative work, time that could be far more effectively invested in patient care. Some of this clerical work is directly related to the reimbursement scenarios described above: attestations; a variety of coding schemes required to meet a variety of payors' requirements; and extraction of certain clinical data elements to meet audit criteria. This list varies from hospital to hospital, but in all cases collecting the data involves virtually all providers. Much of the rest of this clerical administrative time is spent in attempting to assure that the right thing is happening to the right patient at the right time and then documenting what actually did happen.

State-of-the-art hardware and software already being delivered by health care information systems vendors can significantly decrease the amount of time professional providers must spend delivering "paper care" instead of patient care. On-line integrated patient-centered systems assure that the proper information necessary for making both clinical and administrative determinations about a patient's status is collected when available and delivered when and where it is needed, rather than being managed in separate time-absorbing and error-prone steps well after the event.

Point-of-care based automation allows appropriate screening of data to be performed as care is being given, whether it be at the bedside, in the emergency room examination area, or in a physician's office. Since data is captured in real time, it can be checked for appropriateness, completeness, and errors as care is delivered, not days or weeks later as is currently the case.

Of course, detecting such potential problems as they occur not only enhances quality, but also eliminates the large numbers of administrative staff who now attempt to detect such problems retrospectively.

Similarly, automated scheduling and operations optimization capabilities allow care-givers to transfer the task of attempting to assure proper resource utilization to the computer, which does a far better job at this kind of rote process. This kind of task transfer allows care-givers to get back to the job delivering care, rather than spending time attempting to figure out the best way of managing too few resources for too many patients.

With the on-line availability of most or all clinical and administrative data, quality assurance and utilization review activities can be performed at central sites in an automated fashion, rather than on a case-by-case basis using expensive chart reviewers. As practice parameters, case management, care maps, and other concurrent control mechanisms are put into place, the ability to monitor such controls both within the institution and at payor locations using largely automated techniques will not only enhance the quality of care, but will significantly decrease the often error-prone and always clerically intensive evaluation process. Even better, the availability of uniform data will make such reviews more fair and more reliable.

Because of the pervasive nature of the clerical/administrative burden in the delivery of patient care, most state-of-the-art, integrated patient-centered systems have generally been shown to save from one-half hour to one and one-half hours per provider per shift when properly implemented. Since 60–80% of health care operating costs are personnel costs, this amount of time saving can provide a significant level of cost reduction.

Most importantly, these savings are not achieved at the expense of quality. Rather, the elimination of the highly error-prone paper documentation and control system actually improves quality by amounts as high as 40%. Finally, the automation of the bulk of the clinical record allows facile extraction, with little human intervention, of information necessary to perform not only care appropriateness and reasonableness checking, but also to support the kind of medical effectiveness research currently being undertaken by the Agency for Health Care Policy Research and others.

These state-of-the-art approaches to health care automation have an additional advantage as well. Most changes in administrative systems over the years have been designed primarily to save money for payors. New forms, new data screens, and the like have generally been imposed by payors on providers in an effort to make the payor more efficient or to distribute fewer dollars.

Oftentimes these changes cost providers substantially in terms of both time and money. The technologies described above create a unified and level playing field for information, allowing significant paperwork reduction and administrative reduction for both payor and payee. This win-win situation bodes well for the adoption of such new systems.

Now we would like to comment on reforms that would improve billing and claims. First, we recommend that uniform formats, on-line data interchange, and consistent audits and screens for all components of health care delivery be standardized. Many hospitals in different states use the same basic software provided by HIMA HIS members. Nevertheless, each hospital must pay (in one way or another) for modifications to allow that software to respond to the peculiarities of a particular state's non-uniform use of the uniform bill. HIMA believes that mandating a truly uniform bill format, with uniform data elements and codes, accepted by all insurers and public payors would be one of the simplest mechanisms for obtaining immediate health care system-wide administrative savings.

Once unified forms and codes are adopted, the transition to electronic billing and fiscal transfer would be a facile and natural next step. The technology is in place now to deliver these benefits; all that is lacking is a mandate for the uniformity that will make it practical. The basic technology for an all-electronic reimbursement system has been available for some time and is supported by most vendors. However, the multitude of data formats (over 400 by some estimates) has made the necessary technologic investment overwhelming for most. HIBCC has represented the HIS manufacturers in the ANSI X.12 deliberations which have lead to the new ANSI 835 standard, a small but important step forward in this area.

Several HIMA HIS manufacturers have already incorporated on-line verification of eligibility and benefits directly into their health care system-wide information systems. The incorporation of such checking as a seamless part of the hospital's total information system, rather than as a separate stand-alone eligibility checking step, further serves to eliminate administrative overhead, while automatically providing the necessary verification of a participant's insured status.

HIMA also recommends the standardization of audits and screens for billing and clinical data, information which is often reviewed as part of determining eligibility and continuation of benefits. This would provide another singularly significant contribution to reducing administrative costs.

One of the reasons why uniform bills are not uniform is that different intermediaries and carriers have elected to apply different audits and screens to their bills. These audits typically require clinical and administrative data elements which vary from payor to payor. Compounding this is the fact that independent insurers, HMOs, employers, and other payors and auditors impose yet other screens, tests, and audits on data, many of which may not be readily performed using data from standard UB82 submissions.

Today, not only must each health care provider independently determine (via consultation, receipt of memoranda, and other mechanisms) what the rules of the day are, but this information must then be transmitted to the health care information systems vendor, who must then charge for the appropriate programming and testing to allow the institution's information system to provide the appropriate information in the appropriate way, until it changes again.

Multiplied by all 50 states and the large number of payors in each, the management of this audit control task becomes daunting for payors, providers, and informa-

tion systems purveyors, causing a significant administrative burden for each participant. Eliminating the complexities of this process via the use of a standard set of audits and screens would not only be a significant contributor to reducing administrative work, but would likely also improve the quality of the data extracted.

HIMA urges this Committee to give careful and expeditious consideration to administrative cost savings legislation that follows the principles mentioned above. Unlike many of the proposals for reform that are controversial, there is widespread support for legislation that would advance the positive changes in this area that are already well under way in the private sector. The technology is available. The political will to act is all that is lacking.

Finally, Mr. Chairman, we would like to comment on Medicare-type provider payment rates, which are included in some health care reform plans that Congress is considering. HIMA believes that it is premature to mandate the establishment of payment rates using Medicare methodologies. Imposing such rates on a broad basis in a short time frame would have a serious impact on the health sector of our economy. We should have a deeper analytical and policy understanding of the impact this kind of rate would have on non-Medicare services and patients before deciding whether to implement this particular approach.

Thank you, Mr. Chairman, for the opportunity to present our views on health care reform.

STATEMENT OF THE MAYO FOUNDATION

HEALTH POLICY PRINCIPLES

The Mayo Foundation recognizes that national health policy is an issue of major importance, and that a number of significant proposals have been made to reform the national health care system. While Mayo is not attempting to develop a specific proposal, we believe that certain principles should guide policy makers in developing national health policy.

(1) **Guaranteed basic level of health insurance coverage**—some basic level of health insurance coverage should be available to all, regardless of ability to pay, in order to ensure the societal good.

The definition of the basic level of coverage should be made at the Federal level, as well as the decision on how to guarantee individual coverage (employers, individuals, government).

(2) **Individual freedom to purchase additional services**—in order to promote freedom of choice, those who wish to purchase additional services should he free to do so, and should be free to purchase services outside of their coverage plan and without regard to plan reimbursement limits.

(3) **Freedom of choice**—the patient should be free to choose his or her own health care providers, or to voluntarily choose an insurance plan which limits provider choice. It is appropriate for insurers to use financial incentives to encourage the use of high quality, cost effective providers, as long as patients retain the right to choose other providers if they are willing to personally accept responsibility for additional costs incurred Consumer choice is necessary to ensure quality care, competition, and innovation.

(4) **Private providers**—a system of multiple private providers of care should he maintained in order to guarantee freedom of choice and innovation.

(5) **Multiple payers**—a system of multiple payers should he maintained to ensure patient freedom of choice, competition, and innovation.

(6) **Reimbursement**—reimbursement should be adequate to ensure excellence and innovation, but should also provide incentives for efficiency and quality.

(7) **Patient responsibility**—in order to promote a more productive society, the system must encourage patients to take responsibility for their own health, through healthy lifestyles and cooperation in preventing illness and injury. Individuals should also he involved in decisions on their treatment, including decisions on when the use of life sustaining technology to prolong their own life is desired.

(8) **Education and research**—the system must ensure that adequate and identified funding for education and research is provided. The education system must ensure an adequate supply of medical personnel while maintaining high education standards. Medicine should increase research into the effectiveness of diagnostic and treatment modalities, and disseminate the results of such research to practicing physicians. Education and research are necessary to provide for continuously improving future health care.

(9) **Cost control**—high quality care must he provided in a cost efficient manner. A cost control program should include:

(A) *patient financial responsibility* through copayments and deductibles, as a method of controlling utilization and making better choices as to when to use the health care system,

(B) *limiting the tax-exempt status of health insurance to the basic benefit package* as an incentive to include deductibles and coinsurance,

(C) *research to develop practice guidelines* with the goal of eliminating unnecessary services as well as encouraging necessary services,

(D) *support for the testing of new technologies* in order to ensure that they improve outcomes in a cost effective manner,

(E) *malpractice reforms* to reduce defensive medicine and wasted resources,

(F) *elimination of State health insurance mandates* that go beyond the basic level established pursuant to paragraph (1),

(G) *uniform claim forms* for all third party payers in order to reduce administrative overhead costs.

(10) **Quality assurance and ethical standards**—patients should receive high quality care. In order to ensure the integrity of the health care system, physicians and other health care providers should practice in accordance with high quality and ethical standards enforced through a system of responsible peer review.

(11) **Volunteerism and philanthropy**—in order to address unmet health care needs, the system should encourage volunteerism and philanthropy.

STATEMENT OF THE NATIONAL ASSOCIATION OF HOSIERY MANUFACTURERS

The National Association of Hosiery Manufacturers (NAHM) is the trade association representing the interests of those companies in the United States which produce all types of men's, women's, and children's hosiery. NAHM members manufacture and sell 85% of the hosiery marketed in the U.S.

Business employers, both large and small, are becoming discouraged from providing medical coverage for their employees. Large employers see a system with no-cost containment out of control, and small employers are subject to "tightened underwriting," the process used by insurance companies to calculate the risks of covering a particular individual or group. Although small companies employ 58% of all private-sector workers, they lack market power which prevents them from negotiating cut-rate deals with insurers. An estimated 34.6 million Americans (14%) were without any form of health insurance coverage in 1990. More than 85% of these uninsured (over 29 million) are workers or their dependents. Every year the number of people who are "going bare," insurance company language for the uninsured, grows by one million.

The growing ranks of uninsured adversely impact the health care system. For example, hospitals recorded approximately $1.3 billion in free care and bad debt in 1989. Much of that uncompensated care was financed by increased charges, known as "cost shift," to patients with insurance. Demand for uncompensated care is already forcing hospital trauma-care units in emergency rooms to close, which threatens quality care for all.

Congress is now giving widespread attention to the health care problem as evidenced by over 35 legislative alternatives and numerous others in draft form pending between the two chambers. Central to the debate is the issue of how to expand access for the uninsured and underinsured without fueling inflation in health care costs at a time when significant new federal or state spending is questionable.

The NAHM Legislative/Regulatory Committee (LRC) and Human Resources Committee (HRC) have just completed an extensive analysis of the health care reform issue. The Committees recommend a health-care program with built-in cost containment strategies structured to assure competitively priced services and products. They further support the concept of universal health care access on at least a basic level. Accordingly, users would be guaranteed a specified level of coverage, required to pay into the system in some manner, and educated in the efficient utilization of health care programs.

Cost containment strategies would promote preventative care and limit waste, over supply of technology, and excessive over treatment of patients. Medical malpractice reform would be an inherent component of an improved health care system. The present method of cost shifting should be restructured in a manner which provides equitable burden sharing for those providers funding the health care system.

The NAHM appreciates the opportunity to submit comments on health care reform. If you require any further assistance, please feel free to contact me.

Thank you for your time and consideration.

STATEMENT OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

I am Larry S. Gage, President of the National Association of Public Hospitals (NAPH). NAPH's members include over 100 of America's metropolitan area safety net hospitals. These 100 institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over $10 billion, these hospitals provide over 50% of their services to Medicaid and low income uninsured and underinsured patients. This handful of institutions already serve as "national health insurance" by default in most of our nation's urban areas.

I am pleased to have this opportunity to submit testimony on the condition of safety net hospitals in America today and, in particular, on NAPH's concerns with national health reform proposals. Our failure to provide universal health coverage and access to care has for years been the single most glaring deficiency of our nation's health system—one we share only with South Africa among Western nations. In the past two decades alone, there have been nearly a dozen major national health insurance initiatives, offered by the most important political leaders of our era, as well as scores of more modest proposals. Unfortunately, each of these proposals has generated influential opposition as well, virtually paralyzing all efforts to achieve needed reform. As a result, we have advanced very little in this arena since the enactment of Medicare and Medicaid.

My testimony addresses four major points:

First, I would like to bring the Committee up to date on the need for health reform and the changing nature of the patient population that is relying on America's safety net hospitals today.

Second, I have briefly set forth NAPH's principles for achieving national health system reform, against which we believe all of the specific bills before the Committee should be considered.

Third, I have provided comments on major legislative proposals now pending before this Committee, including, the President's proposed health care reforms.

Finally, I will discuss the importance of continuing to address the more immediate needs of our safety net hospitals between now and the implementation of any comprehensive, nationwide reforms.

THE NEED FOR HEALTH SYSTEM REFORM

The level of current attention to comprehensive health care reform is welcome and necessary. The following illustrates the urgency of this situation:

- 34–37 million Americans are completely without health insurance; another 60 million are insured only part of the year or have health insurance that will prove inadequate in the event of a serious illness.
- The Medicaid Program now covers less than half of the Americans who are living below the federal poverty level. Eligibility levels in many states are a disgrace; for example, a family of three living in Alabama would have to earn less than $1416 per year to be poor enough to qualify for Medicaid.
- Physician participation in the Medicaid Program is decreasing rapidly, leaving beneficiaries to seek care in already overcrowded public hospitals or, worse, to forgo needed care entirely.
- Safety net hospitals are bursting at the seams. 55 NAPH member hospitals across the nation average over 80% occupancy with many hospitals approaching 100% occupancy.
- The cost of care for over one third of all patients discharged is not sponsored—even by Medicaid—in NAPH member hospitals; over 40% of all outpatient visits are uninsured.
- The services provided by safety net hospitals are in danger of deterioration as obstetric units, emergency psychiatric units, trauma centers, drug abuse treatment programs, burn centers, neonatal intensive care units overflow at a time when state and local budget crises often require reductions in funding.
- Emergency and clinic patients are waiting longer to see doctors or be admitted. 58% of NAPH hospitals report periodic waits by emergency department patients of 12 hours or more for admission, and half of all hospitals report that some patients are forced to wait more than 24 hours.

Our failure to provide for universal health coverage is forcing our nation's handful of safety net hospitals to treat an ever-broader population of Americans who have no access to other providers because they have lost their jobs, their insurance, or both. Rarely are these individuals able to become eligible for Medicaid—yet rarely can they afford the cost of a serious illness either. Consider the following brief stories, which are representative of thousands of uninsured individuals who receive care from NAPH member hospitals around the country.

A 48-year old woman suffered from severe varicose veins on her leg. She lost her HMO coverage when the factory where she worked closed. Her legs deteriorated and an ulcer developed. She was bed-ridden for six months before seeking treatment at Cook County Hospital. The doctor who examined her wishes that Congress could see what her legs looked and smelled like when she came to the hospital. This woman was treated in the clinic, her ulcers improved and she is now back on her feet.

A 55-year old woman's medical insurance was cancelled when her husband lost his job. The woman had diabetes but her doctor declined to see her when she lost her insurance. After examining her in his office, he sent her to Cook County Hospital with a note reading "please admit patient to hospital." Her blood sugar of 548 was five times the normal level and could have lead to coma and death. The doctors at Cook County treated her diabetes and she now visits the Fantus Health Center to control her blood sugar.

A 34 year old woman lost her health insurance when she was laid off from her secretarial job. At the time, she was undergoing treatment for ovarian cancer but when her insurance ran out, she stopped going to the hospital for treatment. Her neighbor became concerned and called Nassau County Medical Center (NCMC) which said that she could receive treatment even without insurance and immediately set up appointments to treat the woman. She is currently receiving treatment and doing well.

A man who owned his own construction business had a heart condition that had to be monitored. When his company went out of business he stopped going to the hospital for tests. He called NCMC and was told that he could receive the tests regardless of his ability to pay. This gentleman is still going to the hospital for regular monitoring.

A 39 year old woman no longer qualified for health insurance coverage when she was cut back to part time at her grade school secretarial job and could not pay the premiums. She fell ill with severe stomach pains, but could not afford to go to a doctor. When the pains became so extreme that she could not lift her infant son she called D.C. General Hospital and they said they would treat her. She was admitted and diagnosed with multiple (very serious) hernias which required surgery. She was in the hospital for more than a week but is now comfortably back at home and goes to D.C. General for regular check-ups.

A middle-aged man recently lost his job as a real estate developer. When he lost his job, he lost his health insurance. While unemployed and uninsured, he fell in the bathtub and hit his head. He went to Parkland Memorial Hospital in Dallas for treatment and required brain surgery. He was in the hospital for about a week and recovered quickly. When he left, he still had some cognitive problems but he continues to visit Parkland for therapy and check-ups.

A middle-aged woman worked in real estate and depended heavily on her commissions for income. She could not afford health insurance. Recently, she became ill and went to Parkland. She was diagnosed with a spinal cord tumor, but decided not to have surgery because the tumor was not malignant. However, she required a lot of tests and was in the hospital for a long time which really ran up her bill. She still comes to the neurosurgery clinic for check-ups, but is able to do her own urinary catheterization at home.

A 47 year old man who is self-employed remodeling house trailers cannot afford health insurance, even though his wife works, too. Recently, the man suffered a stroke and came to Parkland to be treated. He is now confined to bed, requires round-the-clock care and has a feeding tube. His family was unable to qualify for AFDC to help with expenses, but Parkland was able to arrange for home services anyway.

A middle-aged man came into San Francisco General Hospital with back pain he had sustained while working as a carpet cleaner. He had been laid-off from his job just three weeks prior to coming to the hospital. His wife worked, but even with two incomes they could not afford health insurance. At the hospital, the doctors found that he had multiple slipped discs and had torn some ligaments. He was treated and sent home. He continues to use San Francisco General for his primary care.

In short, while you are debating how to provide access to care, the nation's safety net hospitals are providing that care now, and they are providing it to more and sicker patients than at any other time in our nation's history. It is imperative that policy-makers respond to these needs and enact both incremental and comprehensive health system reforms.

NAPH PRINCIPLES FOR HEALTH SYSTEM REFORM

NAPH has not developed a single, comprehensive proposal of its own, but rather has chosen to outline the characteristics we would like to see in any national health plan that is adopted by the Congress. The following principals, at a minimum, have been endorsed by NAPH member hospitals as essential to any national health plan:

- While incremental improvements are acceptable, the goal of any national health plan must be universal access or coverage for all.
- However, it must be recognized that there will always be individuals who fall through the cracks, even under a universal health plan; NAPH believes that it is both necessary and acceptable to provide access for such persons through the preservation of a strong and well-financed institutional safety net.
- A national health plan must require consistent, national eligibility, service and provider payment standards for the Medicaid program (and any additional residual plan that is adopted to cover the currently uninsured); and serious consideration should be given to the federalization of Medicaid (together with its expansion to serve all of America's medically indigent) or its elimination and merger with Medicare.
- A core national minimum benefit package must be developed that is not so rich as to be unaffordable, yet covers essential preventive, primary care and hospital services, and guards against the burden of catastrophic illness.
- The present system of private insurance can continue under a national health plan, but insurance reform is an essential part of any national health package; the federal government should preempt state regulation to the extent necessary to set national standards for health insurance plans, which include mandating minimum benefit packages on all employers above a reasonable size, reinstatement of community rating, and curbing current trends toward exclusion of pre-existing conditions (or setting post-illness limits on specific diseases such as AIDS).
- Any national plan must include a heavy emphasis on preventive and primary care and must provide adequate support for initiatives to encourage changes in lifestyles.
- Finally, states must be permitted wider latitude to experiment with new plans, including the ability to waive ERISA constraints on the regulation of self-insured businesses.

CURRENT MODELS AND PROPOSALS FOR HEALTH SYSTEM REFORM

Before commenting specifically on the range and type of health reform proposals currently under consideration by the Committee, it may be useful to point out that NAPH's principles can be met in several ways and by several different kinds of proposals, as well as by an approach that combines elements of various bills.

1. Single Payer Proposals

The single payer plans successfully respond to the issues raised by NAPH's principles. They start with NAPH's premise that access should be universal and build upon it. They do not simply reform the Medicaid program, but rather, eliminate it entirely. They allow states the option of administering the program. They also call for preventive and primary care services. While these proposals respond to many of NAPH's concerns, unfortunately, they may not be politically feasible because, critics contend, the nation cannot afford a single payer system.

Senators Daschle and Wofford have proposed a comprehensive approach (S. 2513) that would provide universal access by creating a state-based, single payer system similar to Canada's health insurance program. A federal health care board would set premiums as taxes, establish global budgets and design standard benefit packages.

Senator Bob Kerrey also advocates a single payer system (S. 1446) which would create a universal system replacing Medicaid, Medicare and CHAMPUS. Federal minimum benefits and standards would be established and states could provide additional benefits. The program would be funded through a 5 percent payroll tax, excise taxes, and an increase in several existing taxes.

2. "Play or Pay" Proposals

At present, there appears to be growing interest on Capital Hill in "play or pay" proposals. These have the advantage of leaving largely undisturbed the current health delivery system. At the same time, many of these proposals incorporate the majority of NAPH's principles. They generally call for universal access, though often on a phased-in basis. They also stress reform of the Medicaid program, reform of private insurance and emphasize preventive and primary care services.

The most comprehensive such play or pay proposal is HealthAmerica (S. 1227), sponsored by Senators Mitchell, Kennedy, Riegle and Rockefeller. The "play" component of the plan consists of a public insurance program, AmeriCare, which will replace the Medicaid program. The public plan will be financed by state and federal contributions and administered by the states which will be bound by national standards for eligibility, reimbursement, and coverage. HealthAmerica seeks to reduce the rate of health care cost inflation by encouraging states to establish purchasing consortia for their insurance plans and to set up cost-effective managed care systems. The bill also contains incentives for states to provide beneficiaries with alternatives such as managed care systems.

The legislation would also create a federal Health Expenditure Board which will be an independent agency responsible for creating national health care expenditure goals. The Board will manage negotiations between providers and purchasers to set rates for services that fit within established expenditure goals.

The Pepper Commission advocated a play or pay approach to health system reform, and its recommendations are embodied in companion bills sponsored by Senator Rockefeller (S. 1177) and Representative Waxman (H.R. 2535). These bills would also guarantee universal access to basic health care insurance coverage through employer plans or a public insurance plan.

3. Incremental Approaches

Incremental reform proposals would sacrifice the principle of universal access in the interest of preserving and improving current market mechanisms. In general, incremental approaches will only increase access to the extent the market responds to incentives created by legislation. But, it is doubtful that market incentives will result in universal access.

Chairman Bentsen's proposal (S. 1872) would encourage small employers to offer their employees health insurance coverage by (i) increasing tax deductions for self-employed individuals, (ii) establishing minimum federal standards for benefit packages offered by small employers, and (iii) prohibiting exclusion of pre-existing conditions.

Senator Durenberger's proposal (S. 700) would tax insurance companies that fail to provide certain minimum benefit packages to small business.

4. Competitive Plans

Senator Chafee's competitive plan (S. 1936) closely parallels the President's proposal, which I will comment on below, but differs in several ways. It would rely on tax incentives to increase enrollment in private insurance plans by using tax credits for small business, preventive care and managed care. Senator Chafee's bill would also create a new public program for indigents below 200% of the federal poverty level who are ineligible for Medicaid.

With respect to NAPH's other criteria, a majority of the bills before you adequately meet most of our proposed standards. In addition to expanding access to health care, many of these proposals seek to reform the tort system, expand or reform Medicaid and create demonstration projects. However, none of the current proposals satisfy all of our criteria.

THE PRESIDENT'S PROPOSED NATIONAL HEALTH PLAN

1. Refundable Tax Credit

The centerpiece of the President's health plan—a refundable tax credit for the non-Medicaid poor, coupled to a tax deduction for middle income families—is fatally flawed in a variety of ways. In addition to being very expensive, with no discernable financing method, the voucher plan ignores several important realities about the population at which it is aimed.

While intended to be available "even to Americans who do not file tax returns," in fact it appears that the vouchers will initially be available ONLY to people who do not presently file tax returns—a serious problem in reaching the intended population. Eligibility is set under the plan, not on the basis of the federal poverty standard, but rather on the basis of having an income below the "tax threshold"—the level below which filing is considered unnecessary. Reaching out through the mechanism of the tax system to its nonparticipants will almost certainly guarantee a low participation rate.

The plan discusses the possibility of individuals receiving vouchers even without (or prior to) filing tax returns. What will be the eligibility guidelines? Will unearned as well as earned income be counted? Will there be asset tests in addition to income tests? Who is to determine eligibility under this new plan? The announcement refers vaguely to delegating this responsibility to states (current Medicaid eligibility bureaucracies?) or to federal Social Security agencies. Yet most state Medicaid eligi-

bility bureaucracies are already overworked and underfunded. In fact, because of bureaucratic rigidity and often-absurd verification requirements, such agencies fail in many states to enroll even half of all the potentially eligible Medicaid recipients.

The plan suggests that states should set benefit standards that are "equal in value" to the vouchers. Why does the President believe states will do any better designing a benefit package for his new vouchers than they have in regulating other insurance products? All of the flaws that even the President admits exist under our current system—high administrative costs, adverse selection, etc.—would be unavoidably a part of these new private plans from the outset. In addition, this requirement directly conflicts with the President's aim of permitting small businesses to join together to offer group plans by preempting state benefit standards.

The President's proposal to make coverage voluntary is one of the most serious flaws in his plan. To assume that low income individuals who will be eligible for these vouchers will have the desire and the ability to be "educated consumers" of health care and thus, "shop around" for coverage, is simply preposterous. In fact, many low income patients do not even apply for coverage until they need care, and are usually not certified until long after they have received care. How quickly can eligibility be determined for a sick individual who has not previously enrolled in any plan? Will this be possible under the President's voucher plan? Will all insurers be required to accept patients receiving care at the time they apply? Will the hospital itself have to enroll a sick individual in a suitable plan? If the patient proves to be eligible, will coverage apply retroactive to previously rendered hospital services, as it does under Medicaid?

Finally, how soon after unemployment or loss of insurance will an individual be eligible for a voucher? What is the basis for this determination? Will past income be used as a test? How far back will they look? Six weeks? Six months? Will that result in a coverage gap? Will an applicant be able to rely on projected future income (or lack thereof)? How will that be determined?

2. Proposed Medicaid Reforms

The President's Medicaid proposals to limit Medicaid payments to acute care hospitals are also a matter of serious concern. If, as the plan proposes, only acute care costs are capped (i.e., limited to CPI inflation plus an as-yet undetermined 2–4% add-on), and this is done only for the non-elderly poor (i.e., Medicare-Medicaid crossover patients would not be included in this equation), this virtually eliminates Medicaid as a potential funding source for the President's plan. The plan would also exclude "disproportionate share" payments from any CPI-related cap but strongly suggests that states should be able to reduce such payments as the voucher plan is implemented. Capping the growth of such a limited universe of Medicaid payments would generate serious problems for hospitals serving the poor.

3. Delegation of Federal Responsibilities to States

One of the most peculiar aspects of the President's plan is the strong suggestion that states **should take over his voucher plan and merge it with Medicaid,** using current DSH payments as one funding source for such an expanded plan. What is especially annoying about this aspect of the proposal is that the President went out of his way in his Cleveland speech to blast Democratic proposals, including a Canadian-style single-payer system, as "turning our health system over to government." **Yet his own plan is in effect a blueprint for doing precisely that**—and in a Canadian-style manner, to boot. Apparently, the President either was not informed or failed in his speech to point out that the Canadian system is in fact run through the Provinces, and that Provincial plans differ from one another. The fact is, the President's plan not only permits, but actively encourages states to do their own thing—with a substantial infusion of Federal money to augment their current Medicaid spending. So, instead of one national governmental program—we'll have 50! This would only perpetuate and magnify all of the state-by-state inequities of our current Medicaid program.

4. Other Concerns

In addition to those major flaws in the President's plan, there are a number of other elements of the plan that are of concern.

The Medicare proposals, while ambiguous to a certain extent, are potentially troublesome, since they focus almost exclusively on limiting the rate of increase in provider payments. In particular, reductions in medical education and DSH payments are clearly envisioned, as "the subsidies are made duplicative by the new tax credit and deduction." (It should be noted, however, that this is the first time a Republican Administration has even tacitly acknowledged that the Medicare disproportionate share adjustment is a valid expenditure for cross-subsidizing care for the non-Medicare poor.) In addition, the proposed consumer-oriented "blue books" on "average

cost and quality of services" could perpetuate the mistakes of Medicare mortality data.

5. Positive Aspects of President's Plan

For all of its flaws, we believe there are a number of things to be admired and supported in the President's plan. While these elements by themselves do not add up to system-wide reform, they clearly deserve to be considered by the Congress as a part of any more comprehensive plan.

- The President's proposals for insurance system reform are impressive and highly supportable, including the elimination of preexisting condition requirements, portability, and enabling new kinds of group plans to be created for small employers (apparently waiving antitrust laws as well as preempting state insurance regulations in the process).
- Malpractice reform is another area where Federal leadership is long overdue, and where the President's proposals appear to have teeth.
- Perhaps most gratifying from NAPH's perspective is the President's support for substantially increased funding of Community Health Centers, Migrant Health Centers and the National Health Service Corps.
- Secretary Sullivan is also to be praised for the inclusion of preventive health measures in the President's plan. However, we are concerned about the budget for these measures because, try as we might, we cannot identify anywhere near the $26.4 billion in projected FY 1993 spending that is included in the President's plan for preventive health programs.
- Some of the President's proposals for administrative streamlining are long overdue, especially his proposals for electronic claims processing and greater standardization of medical claims. We are concerned, however, that while the President attributed considerable systemic savings to these proposals, he developed no mechanism for channeling those savings into needed expansions of coverage and service for the currently uninsured.

6. Lack Of Funding

Ultimately, the truly fatal flaw in the President's voucher program is that he proposes no method of paying for it. Even where savings are assumed from other reforms, no effort is made to translate those savings into real program expansions. And the few money-raising provisions that were apparently in the President's original proposal—means testing Medicare premiums for high income retirees and placing a cap on the deductibility of insurance premiums for the wealthy—did not survive the final cut. Yet these financing mechanisms and others, as unpalatable as they may be to some constituencies, must be considered as fundamental to any plan for reform, alongside an enforceable mechanism for ensuring that all employed workers have adequate coverage.

THE NEED FOR CONTINUING SUPPORT FOR SAFETY NET HOSPITALS

The President has suggested that Medicare and Medicaid disproportionate share payments could be substantially reduced under his plan. This implies that, if his plan were enacted, there would also no longer be a need for the institutional health safety net that relies on these payments. We can only note that the same thing was said about the enactment of Medicare and Medicaid. Given the likelihood that future reforms will continue to be incremental and piecemeal, NAPH believes strongly that a substantial need for our public health safety net will continue in our nation's metropolitan areas.

The recent riots in Los Angeles clearly underscored how our current health safety net fills gaps in our health care system. Reports now emerging tell of extraordinary heroism and dedication by L.A. County medical and administrative staff, especially at the Martin Luther King/Drew Medical Center, in the middle of the war zone. Without County facilities and services, the death toll would have been far higher and many of the injured would have been worse off. The care that was delivered had nothing to do with the insurance status of the riot victims but rather with the geographic location of safety net institutions with the capacity to provide the needed care. The health care marketplace had nothing whatsoever to do with the availability of these essential health services.

At the same time, however, it was clear that the County system in Los Angeles was stretched to the very limit. The EMS system broke down entirely, for obvious reasons, and while King/Drew Medical Center experienced an amazingly low 34% absentee rate among employees, it is not an over-staffed institution to begin with, and may staff members had to labor around-the-clock to keep the facility open. Without constant attention and support for the needs of city and county health sys-

tems, this level of care will simply be unavailable in the future. Even if national health insurance were adopted this year, these institutions will need continued support well into the future because:

- Any new system is likely to be phased in over a long period of time.
- Even with coverage, many of our current uninsured will be little better than Medicaid patients, who today find their access restricted in many states to those "open door" hospitals and clinics who will serve them.
- It is also important to recognize that many of the current uninsured also suffer from a variety of health and social problems very different from those of middle America—AIDS, drug abuse, tuberculosis, and teenage pregnancies are often augmented by homelessness, joblessness, and lack of education; while no health care provider can fully cope with all of these problems, our urban safety net hospitals are the only ones even trying to do so today.
- In addition, we must recognize that even for insured individuals today, with the dramatic cost containment efforts already being imposed by both public and private payers, many expensive and unprofitable services (such as trauma, burn care, and neonatal intensive care) are also far more likely to be available in safety net hospitals.
- Finally, many safety net hospitals are simply located in the geographic areas where most of our uninsured Americans reside—areas which, even if national health coverage were fully implemented, most other health care providers will continue to be unwilling or unable to serve.

For these reasons, we must be extremely careful about dislodging any current funding mechanisms for safety net hospitals until we are certain that we have a workable system that is already fully implemented and able to take their place. The final section of my testimony focuses on a number of short term needs that must be met over the next several years to support the nation's safety net hospitals.

CAPITAL FINANCING FOR SAFETY NET HOSPITALS

Safety net hospitals face a substantial need for adequate capital to rebuild and equip our nation's health infrastructure. A new NAPH study estimates that there are at least $15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. In order to meet these needs, a new Federal capital financing initiative is clearly needed.

NAPH has drafted a major new capital financing bill that has recently been introduced in the House by Representative Pete Stark (H.R. 4521). This bill would finance up to $15 billion in capital improvements for disproportionate share hospitals, as well as provide loan guarantees, interest rate subsidies and grants to meet both general and specific safety net capital needs. Eligibility for such a new program would involve a high standard of need in urban and rural areas, and hospitals accepting assistance would have to be willing to meet long-term indigent care and community service requirements, and perhaps other reporting and utilization requirements. We look forward to working with this Committee to develop appropriate legislation in this area.

MEDICAID REFORM

We would like to take this opportunity to point out that continued reform of the Medicaid program is essential, whether or not a consensus is reached on the broader issue of health system reform. Recent improvements in the Medicaid program have expanded eligibility for pregnant women and children, permitted states to continue using a variety of mechanisms for providing extra payments to disproportionate share hospitals, and permitted public and private hospitals to participate in the financing of Medicaid expansions through voluntary donations and the transfer of funds by local governments to states. In addition, states like Florida, New York and New Jersey have used provider taxes or all-payer systems to redistribute revenues and enhance Medicaid payments. It is imperative that states be permitted to continue to make use of these alternative sources of revenues, at a time when many are suffering severe budget crises.

However, even with the availability of the augmented payment sources described above, only about half of all states pay significant differentials to "disproportionate" safety net hospitals. In fact, as a result of the Medicaid legislation enacted last December, it may prove more difficult in the future for states that have not already improved Medicaid disproportionate share hospital payments to do so. A number of states continue to subject hospitals to inadequate base payment rates as well, as

is evidenced by the proliferation of lawsuits brought by hospitals against state Medicaid agencies around the country. **Both reasonable and adequate Medicaid payment rates, and meaningful disproportionate share hospital payments, must be enforced upon all states.**

DISPROPORTIONATE SHARE AND MEDICAL EDUCATION ADJUSTMENTS

"Disproportionate share hospitals" continue to experience significant operating deficits of over $9 million or 6% of the average operating budget for these hospitals. While Medicare patients are a relatively small proportion of the patient load in safety net hospitals (only 10% compared to 34% on average for the hospital industry), Medicare DSH adjustments play an important role in easing the strain of deficits on these hospitals. Medicare is usually the single most important non-indigent payer in many safety net hospitals, and as such, constitutes an essential part of their patient care revenues. Growth in this program from just $200 million in its first year to well over $1.4 billion in 1991, together with Congressional restraint in making any further reductions in the indirect teaching adjustment, has resulted for the first time in real dollar gains in Medicare reimbursement for safety net hospitals, although these gains have not succeeded in erasing their deficits.

DIRECT OPERATING SUPPORT FOR SAFETY NET HOSPITALS

While Medicare clearly has a role to play in sharing the financial burden of safety net hospitals, it is also true that additional measures are needed. In particular, as the debate over universal health coverage drags on, it is imperative that the Congress enact some form of **nationwide institutional support for safety net hospitals.**

Ideally, this should take the form of a national uncompensated care trust fund, with dedicated sources of revenue. Legislation developed by Representative Rostenkowski and introduced in the House last year (H.R. 754) could serve as a model. That legislation would create a trust fund with the proceeds of a small tax on health insurance premiums. Such a tax could generate potentially $600 million to $1 billion for distribution to high volume providers of uncompensated care. Other potential funding sources that have been mentioned include taxes on alcohol, tobacco and firearms, as well as a national excise tax on hospital utilization.

CONCLUSION

I thank the Committee for this opportunity to submit testimony on behalf of our nation's safety net hospitals and to share our views on national health reform proposals. We hope to have further opportunities to share our views and to work with the Committee to arrive at a rational and pragmatic approach to achievable health care reform.

STATEMENT OF THE NATIONAL EMPLOYEE BENEFITS INSTITUTE

The National Employee Benefits Institute ("NEBI") is an organization composed of Fortune 1000 companies. NEBI members wish to assist in the development of a comprehensive health care reform program for the U.S. NEBI would like to thank Senator Bentsen and the members of the Committee on Finance for permitting organizations such as NEBI to submit comments regarding comprehensive health care reform.

SCOPE OF REFORM

General. NEBI recognizes that the health care system in the United States is in crisis. No one group is singularly responsible for this crisis, nor can one group resolve it. All interested parties—health care providers, consumers, payors, insurers and others—need to be involved in developing a comprehensive reform strategy. Due to the interdependent nature of the issues, NEBI's comments must be viewed as a complete package, and not as separate recommendations.

Need for Overall Reform. Fundamental and systematic reform of our health care system is needed in order to control the problems of cost, access and quality in the United States. Such reform should preserve, as much as possible, that which is good about our current health care system. While, it may be necessary to implement this reform through a gradual step-by-step process, incremental reform should only be done as part of an overall systematic national health care reform strategy. NEBI believes that separate state-by-state reform or incremental reforms will merely push

more money into the system without satisfactorily addressing access, cost and quality.

HEALTH CARE COSTS

Controlling Costs. The total cost of health care in the U.S. is too high, both in terms of what value our citizens receive for the dollars spent, and as compared to what our international competitors spend to provide health care to their citizens. Reform proposals should be structured to assure reasonable control of these costs. Equally important, they should establish mechanisms that, in the aggregate, will bring the rate of inflation in these costs down to levels more consistent with the growth of other sectors of the U.S. economy.

Fair Distribution of Costs. Larger employers and their employees have carried an unfair triple burden by (1) paying for their own health care, (2) paying taxes to support health care for others, and (3) paying cost shifts from those employers that provide no health benefits and those government health programs which provide low provider payments.

NEBI members and their employees are willing to pay their fair share, but expect reform proposals to redistribute the costs more equitably so all employers, individuals with the ability to pay, and government programs pick up their fair share. In a competitive model system, government programs should not have the power to legislate fees, but should be required to negotiate provider network fees in the marketplace as private payors do.

Consumer Responsibility. The principal goal of our private insurance systems and public health care delivery systems is to make medical evaluation and treatment services reasonably available to those who suffer specific illness or injury. Consumer responsibility for the frequency and cost of the medical services they choose should be promoted through significant cost-sharing of premiums and service fees.

Improving the health status of our population is primarily an individual responsibility. School based programs should assist by providing education in preventive health, personal care, coping and adapting skills and effective medical consumerism. Similar programs should be available to the adult community as well. Financial incentives should be promoted which encourage individuals to improve those poor health habits and correctable medical conditions which predispose one to more serious illness or injury.

Provider Responsibility. Health care cost, quality and access cannot be controlled by government or private payor programs alone. Providers of health care must assume greater responsibility for these three variables. To assure provider responsibility, provider network delivery models should be promoted. In these models, control of the cost and quality of care provided is pushed down to local organized delivery groups which have a significant financial and professional stake in providing effective, efficient and acceptable services. Providers who purposely commit fraud or abuse, or those who are unable or unwilling to improve significant quality problems should be excluded from or appropriately restricted in these organized delivery groups.

ACCESS TO HEALTH CARE

Health Care Access Limited. Access to health care in the U.S. is a problem that must be addressed. Reform proposals should assure that every citizen in the United States has reasonable access to at least a minimum specified level of health care services. Reasonable access to health care does not mean the same thing as having health insurance coverage, nor does it mean that every citizen should be guaranteed the financial ability to go to any health care provider he or she wants. Reasonable access to health care services can be facilitated through public or private insurance systems, or provided directly through expansion of public health service or private clinics and hospitals, school-based programs, or through a range of other managed delivery mechanisms.

Mixed System of Funding and Delivery. Reform proposals should build on our tradition of competitive insurance options and mixed funding, while providing a solid public "safety net" to assure reasonable access to all citizens through a public health delivery system. Individuals and groups should retain their right to purchase premium based private insurance options. The poor and otherwise uninsured should be provided access to care through a public, tax based system. To allow maximum access to competitive private insurance options, the individual underwriting and community rating aspects of "small group reform" should be enacted. In addition, individuals and employers should be allowed to form group purchasing arrangements without exposure to anti-trust liability, and health insurance costs for the self-employed should enjoy the same tax-advantaged status that it does for employers. Risk

pools should be encouraged to permit those who cannot afford or obtain coverage because of health conditions to be covered for at least catastrophic events.

Those employers that do not offer insurance, and those individuals who have the means but do not purchase insurance, should have to pay a special tax designated to pay for their anticipated costs in the public program. The poor, medically indigent, and other uninsured individuals should be provided access to at least a minimum specified level of care through a publicly operated or managed health care delivery program.

Choice of Benefit Level. Employees and employers should retain the right to decide how important full health care insurance coverage is as compared to other salary, benefit and personal spending priorities. All employers should be required to offer, at a minimum, a policy which covers a good percentage of any catastrophic and unpredictable annual health care costs as well as certain preventive care programs (especially for children) which have proven value. The minimum specified level of health care services accessible through the public "safety net" programs should be somewhat more comprehensive, based on the inability of individuals in that program to purchase additional private insurance or pay directly for noncovered services.

QUALITY OF CARE

Quality of Services. Reform proposals should address the quality of health care delivered to our citizens. But health care reform must view quality in a broader context than individual patient treatment episodes. Quality improvement programs should be able to continually analyze and improve the distribution, effectiveness and relative cost efficiency of the care provided and its overall impact on population health indicators.

To address quality in this way, reform proposals should include mechanisms to systematically collect data, generate comparative information, conduct outcomes research and produce optimal treatment protocols. Likewise, a system of review should be established to assure that new and existing medical technology and procedures meet effectiveness and relative cost efficiency standards prior to general diffusion into the marketplace.

OTHER REFORM PROPOSALS

Tort Reform. Significant tort reform that reduces the chance of frivolous malpractice suits, identifies problem providers for corrective action, and ties award levels to the actual cause and extent of injury.

Federal Preemption. Federal preemption of state benefit mandates and state anti-managed care laws. Elimination of any law that limits the ability of multiple employers to act as a single purchasing group.

Health Planning. National and regional health planning to evaluate the allocation of resources and the overall effectiveness of the system.

National Identification System. National individual provider identification system for use by all payors to allow better identification of provider quality, cost and acceptability.

Simplification of Administration. Simplify the administration of insurance based benefits programs by encouraging a standardized form of paper and electronic eligibility identification, claims submission, payment for services, data collection and reporting.

Medical Education Reforms. Significantly restructure the funding for medical education and treatment so as to increase the percent of physician and non-physician primary care givers and encourage more efficient alternative approaches to care.

STATEMENT OF THE NATIONAL REHABILITATION CAUCUS

This statement is submitted on behalf of the members of the National Rehabilitation Caucus (NRC) listed below. The NRC is comprised of national organizations representing a wide range of health and rehabilitation professionals, consumers and institutional and home and community based-providers of rehabilitation services. As a broad based and diverse coalition, the NRC has a unique and important perspective on the problems of our current health care system and its member organizations have a compelling interest in the evolving debate on health care reform and costs.

I. BACKGROUND

Rehabilitation is an integral part of the current health care delivery system. Rehabilitation services are individualized, goal-oriented medical services designed to maximize functional ability, prevent further deterioration, reduce or eliminate pain and promote quality of life and independence for people, who through accident or illness, have acquired a temporary or permanent disability. These services are provided by qualified health care professionals including physiatrists, occupational therapists, physical therapists, speech-language pathologists, audiologists, rehabilitation nurses, respiratory therapists, and others such as psychologists and social workers. Rehabilitation services are delivered in a variety of settings, depending on diagnostic and therapeutic requirements, including hospitals, nursing facilities, comprehensive outpatient rehabilitation facilities, rehabilitation agencies, pain centers, other clinics and independent practitioners.

Millions of people receive rehabilitation services annually—people who have had a heart attack or stroke, have arthritis, cancer and other painful disorders or a neurological disorder, have had joint replacements or have experienced a traumatic accident or debilitating illness, or suffer from pulmonary disease such as emphysema as well as children with congenital or acquired physical impairments.

Rehabilitation is goal oriented and cost effective in that it reduces the potential for subsequent complications and thereby the likelihood of recurring medical treatment. Over 80% of people receiving rehabilitation services resume independent living. Peter Drucker, a well known management consultant, has said, "The health area in which we have made the greatest progress in recent decades has been rehabilitation; to restore badly injured people to functioning. Of all health care dollars, they are the best spent."

A survey conducted by the Health Insurance Association of America found a savings of $11 for every $1 invested in rehabilitation services and a savings per claimant of between $1,500 and $250,000. Similar results have been shown in studies conducted by several insurance and case management companies. Northwestern National Life Insurance Company finds that rehabilitating workers can save companies $30 for every $1 spent. Available data indicate that premium costs, if any, associated with coverage of medical rehabilitation services are modest when contrasted with potential cost due to lack of prevention of complications, institutionalization and extended institutionalization. For example, according to 1990 figures from Blue Cross/Blue Shield of Massachusetts, the cost of full coverage in inpatient and outpatient settings of occupational, physical, and speech language pathology therapies and services amount to 1.5% of the average individual monthly insurance premium or $3.70.

II. COUNTS

In light of the above, we have reviewed the major measures health care reform measures, including S. 1872, S. 1227 and S. 2513 and wish to offer specific comments. Our broad statement of principles is attached.

A. Coverage

Our primary concern is the approach taken in the benefits packages. We urge that appropriate rehabilitation services and providers be recognized explicitly within any minimum benefits package incorporated into health care reform legislation. Therefore our first recommendation is that the definition of inpatient and outpatient hospital care be clarified to include inpatient and outpatient rehabilitation care. Second, we recommend that community based medical rehabilitation services delivered outside the hospital also be included in the benefits package. To do so would parallel current practice in covering these services. While the Medicare benefit package is a good starting point, we also support the recognition of habitation services in S. 2513, the American Health Security Plan, introduced by Senator Daschle on April 2, 1992.

The Medicare definition of hospital specifically references rehabilitation hospitals and the therapeutic services they provide. Medicare has traditionally covered inpatient and outpatient rehabilitation hospital services since 1965. See Sections 1861(b), definition of inpatient hospital services, and (e) definition of hospital, (s) definition of medical and other health services, (p) outpatient physical therapy services, (g) outpatient occupational therapy services, and (cc) definition of a comprehensive outpatient rehabilitation facility.

Most Medicaid programs also cover inpatient and outpatient rehabilitation hospitals services. Also at least 75% of the states cover outpatient physical therapy and each state offers at least one outpatient rehabilitation service. See Sections

1902(a)(10) and 1905(a)(13). Also community based rehabilitation services are provided through the home and community based waiver programs.

Commercial insurers also recognize these services. The Health Insurance Association of America has issued two bulletins regarding the coverage of rehabilitation services by insurance carriers.

Finally, many Blue Cross and Blue Shield plans cover at least inpatient rehabilitation hospitals and units and the services they provide and in recent years have broadened coverage of community based rehabilitation.

B. Using Medicare Methodology as Optional or Mandatory Rates

Several of the bills require the Secretary of HHS to establish optional payment rates for hospitals, physicians and such other classes of providers as the Secretary specifies. These payment rates are to be based on Medicare payment rates and methodologies. Such methodologies for payment for inpatient and outpatient hospital services may provide for an adjustment to take into account the costs incurred by hospitals in providing care for which no or only partial payment of the rate is made.

Currently most rehabilitation hospitals and units are Medicare providers and are exempt from the Medicare diagnosis related group (DRG) based prospective payment system (PPS) under which most acute care hospitals are paid. They were excluded because the DRGs did not include data from rehabilitation hospitals and units and do not recognize diagnoses with long lengths of stay. Comprehensive outpatient rehabilitation facilities (CORFs) are paid on the basis of reasonable cost. Other rehabilitation providers and professionals are paid on a basis of reasonable cost or charges.

Under current law the effect of any such charge for rehabilitation providers would be to restrict revenues for all patients to cost, as defined by Medicare law and regulations, and for hospital providers impose TEFRA limits on all such payments for inpatient services. Other rehabilitation providers would be equally affected. While most of the examples that follow reflect the impact on rehabilitation hospitals, conceptually the outpatient providers and the professionals would be similarly affected if Medicare methods and rates were applied to them. The result would be disaster for this critical element of the health care system for the following reasons:

—If there continues to be any uncompensated care, without more specific provisions for recovery of these costs, providers would have no way to cover the cost of this care and would be forced to deny many services to indigent patients or face ruin,

—Providers would not be able to generate adequate funding for working capital for ongoing operations and/or new programs or for replacement or improvement of physical facilities,

—Because of inequities in the TEFRA system providers would be paid widely differing rates for the same services, compounding the current effect of Medicare policy,

1. Uncompensated Care.

Generally, Medicare cost reimbursement methodology does not recognize the cost associated with uncompensated care in calculating reimbursement for Medicare patients. In fact, Medicare reimbursement is actually reduced if a hospital's charity load increases. This is because Medicare cost reporting practices require that costs of operation be allocated to indigent patients (and thereby away from Medicare) in determining the cost of serving Medicare patients. Thus, present Medicare policy contains a clear and powerful disincentive for providers to take charity patients.

This policy is bad as things stand. If the Medicare policy were extended to all payers it would eliminate the ability of hospitals to generate any revenues to cover indigent care. Unless coverage is provided for all patients, the adoption of a cost-based payment system for patients with coverage means that there is no way to finance services to those without coverage.

To properly effect this policy for cost-based providers, any legislation should provide that all charges which are not collected, in whole or in part, should be excluded from calculation of Medicare costs and any additional cost per discharge arising from such exclusion should not be subject to TEFRA limits(for inpatient services), the broader implications of which are discussed below.

2. Cost Principles and Capital Generation.

Any such change must also recognize all the real costs of delivering health care that Medicare does not now recognize either for inpatient or outpatient services or for other outpatient services such as those delivered by comprehensive rehabilitation outpatient facilities. Medicare's reasonable and allowable cost principles simply do

outpatient facilities. Medicare's reasonable and allowable cost principles simply do not recognize as operating costs the real cost of delivering health care to the Medicare population. This is best illustrated by the failure of Medicare payment methodology to recognize the need for working capital and, because depreciation is based on historic cost, to provide adequately for capital investment in new facilities and equipment. Currently, hospitals are able to compensate for these deficiencies in Medicare policy by higher rates for other payers. If this door were closed, cost-based providers such as rehabilitation facilities would be gradually, or not so gradually, driven out of business.

It is no secret that to adequately provide for Medicare beneficiaries, providers shift costs to other payers to cover their costs at a minimum. Certainly this is viewed with disdain by policy makers. However, even if every provider were paid the same, i.e. Medicare costs, and no shifting were possible, the simple problem of not enough payment to cover costs still remains. The basic problem is that Medicare does not pay an adequate amount for a financially healthy entity, be it nonprofit or for profit, to survive. It does not allow a return on funds, be they characterized as surplus or profit, to reinvest in the strength and growth of the facility. In addition to capital, this would include putting funds into programs such as expanded patient care, modern equipment and the like. Until this critical fact is addressed, expanding Medicare rates and methods to all payers is simply a way to cut provider reimbursement. It is not true cost control.

3. Effects of TEFRA Limits.

The problems addressed above with Medicare payment methodologies exist even without the effect of TEFRA limits. When the effect of limits is added, there is a clear formula for disaster.

The Tax Equity and Fiscal Responsibility Act of 1982 provides for the imposition of limits on Medicare cost reimbursement for inpatient rehabilitation services. Such limits are based on Medicare operating cost per discharge in a base year. This amount is updated annually, theoretically to recognize the cost of inflation. The maximum amount a hospital receives in subsequent years is the number of discharges times the cost per discharge. If the hospital's costs exceed this cost per discharge it does not receive additional funds from Medicare. However for cost reporting periods beginning on or after October 1, 1991 it can receive 50% of the amount by which it exceeds its limits up to 110% of the limit. If the facility's Medicare costs are less, it receives a small incentive payment.

TEFRA is based on the presumption that all operations' remain stable. It presumes that case mix, severity, utilization, and patient acuity remain stable; that the updates will be adequate to account for inflation and any changes; and that management can keep costs within the target limits if there is any change. However, in reality, this is not true. These assumptions are no longer proving to be valid. Case mix, utilization, and acuity have changed in most facilities since their TEFRA base years, with the result that many facilities have costs above their limits. As a result many facilities' costs have increased. Because updates have been below the rate of inflation, the only way for most facilities to stay below their limits is to cut average Medicare length of stay. The principal way to do that is to, on average, take less complicated cases. Hence, there is an inherent bias against admitting more complicated cases that could benefit from rehabilitation.

A substantial majority of hospitals and units subject to TEFRA limits are exceeding them. For the most recent period for which data is available through HCFA, FY 1989, 29 rehabilitation hospitals and 287 rehabilitation units were over their limits with aggregate cost over Medicare reimbursement of approximately $115 million.

If such limits were applied to payment for all patients, most of these freestanding hospitals would not survive and undoubtedly many of the units would be discontinued.

One of the NRC members, the National Association of Rehabilitation Facilities (NARF) is now engaged in a major research effort to develop a patient classification system for inpatient rehabilitation. This is essential to consideration of a PPS for rehabilitation. Replacement of the TEFRA system is badly needed. It certainly should precede any broader application of Medicare payment methodology.

Rehabilitation hospitals and units are in a far different position under Medicare than are hospitals under the Medicare PPS. Whatever the defects of the latter, there is the potential for some profit margins to be applied to costs of uncompensated care and other requirements not recognized by Medicare principles of cost reimbursement. Under cost reimbursement there is none. Any reductions in cost reduce Medicare reimbursement. Any costs above TEFRA limits are not reimbursed, except to the extent allowed by HCFA-granted adjustments, an arduous process at best.

4. Site Substitution.

Any change in payment will create incentives to move services beyond the door of the acute hospital as they seek to shift costs to other sites. This is one of the phenomena that has occurred with the institution of PPS. Rehabilitation hospitals and units and other rehabilitation providers saw and still see Medicare patients coming to their facilities much earlier from onset of their condition than prior to the PPS. There would be additional pressure on acute hospitals to send all patients to other sites, including rehabilitation, if Medicare rates and methods were used for all payers.

5. New Populations.

If the payment rates were extended to other payers, a number of new populations would be covered. Many younger rehabilitation patients are more severely ill, need more intense services, and have longer lengths of stay. For example a significant number of younger stroke patients are more severely debilitated than adults. Expanding Medicare would be based on the false assumption that payment reflects practices that are parallel for this group and Medicare patients. Typical new groups would be children with congenital or acquired disabilities, and younger adults with spinal cord injuries and traumatic brain injuries. The needs of these populations would have to be reflected by increasing the payment rates to account for the increases in the cost of treating these patients, either on a per discharge or per diem basis.

6. Conclusion

Medicare payment methodologies should not be applied to all patients treated by rehabilitation providers unless and until, at a minimum, there is coverage for all patients or alternative means are provided for coverage of uncompensated care and the TEFRA system is replaced by a rational and equitable alternative.

C. Definition of Small Employer

Several bills define small employer as one with 1–51 employees. We recommend that this number not be increased, and would prefer that it be decreased to 25 employees.

D. General Requirements

The NRC supports the alternative mechanisms that are to be available within a state to assure insurance availability to the defined small employers. For example under S. 1872, this mechanism includes a program for assigning high risk groups among all insurers. We support the need to address and assure access for high risk groups. The NRC has heard too frequently of various occupations and professions that have lost insurance or cannot afford it. Many times we find that the patients our facilities serve are in these occupations.

E. Community Rating

Various bills allow insurers to make certain adjustments for premiums across small employers and requires a form of community rating based on an area no smaller than a county or an area that includes all areas in which the first three zip code numbers are the same. The NRC supports community rating over group rating to lower premium costs by spreading the risk.

F. Copayments and Deductibles

The NRC cautions that the Committee consider that even a 20% as a copay or deductible may prove too high for some persons with disabilities.

G. Preexisting Conditions

The NRC supports the provision on non-discrimination based on health status. We also support the intent to limit exclusions for preexisting conditions to 6 months. We would recommend that all preexisting conditions clauses be deleted to eliminate the possibility of lack of receipt of health care for persons with disabilities and therefore the almost total bar to coverage that these provisions create.

H. Portability

The NRC supports provisions to assure the portability of insurance so that employees are not faced with staying in jobs that are unsatisfactory or losing health insurance if they leave. This is the fabled "job lock".

I. Managed Care

NRC has several concerns with these types of managed care programs based on the current experience of our members. First, with respect to any type of utilization review program, we recommend that reviewers have experience and training for the

area they are reviewing. This means that physical therapists must review the work of other physical therapists and physiatrists or other physicians with training and experience in rehabilitation must review the work of similarly qualified physicians. All too frequently this is not the case with disastrous results.

Under current managed care plans for the non-elderly, our members find that many HMOs are not providing full and adequate coverage for inpatient and outpatient rehabilitation hospital and other outpatient rehabilitation services. In some quarters this is due to a fear of additional costs. Even the federally qualified HMOs that by federal regulation are to deliver 60 days of rehabilitation services often do not. The result is that the patient is not restored to an independent life when this may be possible. For many patients, this means transferring to Medicaid and then finding themselves dependent on services based on the lottery of which state they live in. Also, NRC members have heard that in over 9 states that Medicare risk contracting HMOs will not' inform enrollees about their rehabilitation benefits and send them to a less appropriate level of care denying them a needed benefit that in many cases, as with the younger age groups, is medically necessary and required because of illness, injury, or their disabling condition.

J. Other

1. Outcomes Research.

NRC supports continued outcomes research. With respect to rehabilitation, we firmly believe that it will be shown to be cost effective and efficient.

2. Prevention.

We commend inclusion in the benefits package of several recognized screens and procedures which when utilized help detect disease early and thereby prevent death and serious illness. Rehabilitation plays a major role in prevention of certain complications such as bed sores and deep vein thrombosis, for example.

Rehabilitation is cost effective because it teaches families/caregivers and patients self care and prevention of future problems which reduces potential future medical costs and overutilization of health services. Government/payer attention to wellness, prevention and healthy lifestyles/habits has long been the focus of rehabilitation so rehabilitation is well positioned to assume that role. Rehabilitation also maximizes potential, preserves gains made and enables clients to be independent of the health care system thereby further reducing costs. Prevention and healthy lifestyles are cost effective.

3. Access to Rehabilitation Services.

In many regions of the country there are shortages of rehabilitation personnel, including physical, occupational, and speech therapists. These shortages are especially acute in rural and urban areas.

Many states have responded by allowing care to be provided in innovative ways which serve to provide greater access to rehabilitation services. Some states have created special benefits for rehabilitation services in health insurance laws which some bills would preempt with lesser benefits. Any federal plan should not inhibit innovative state responses and in fact build on the states' experiences without rationing care.

We would be pleased to discuss any of these concerns and recommendations with you or your staff. If you have any questions please feel free to contact Carolyn Zollar, Chair of the NRC, and General Counsel and Director of Government Relations, National Association of Rehabilitation Facilities 703–648–9300 or Fred Somers, Vice Chair of the NRC and Director of Government Relations, American Occupational Therapy Association, 301–948–9626.

Attachment.

NRC National Rehabilitation Caucus

A coalition of groups for the advancement of rehabilitation
through advocacy, education, research and communications

POSITION STATEMENT

ON

HEALTH CARE REFORM

AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION
AMERICAN ASSOCIATION FOR COUNSELING AND DEVELOPMENT
AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AMERICAN CONGRESS OF REHABILITATION
AMERICAN FEDERATION OF HOME HEALTH AGENCIES
AMERICAN PAIN SOCIETY
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
AMERICAN PHYSICAL THERAPY ASSOCIATION
AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION
ASSOCIATION OF REHABILITATION NURSES
NATIONAL ASSOCIATION FOR HOME CARE
NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS
NATIONAL ASSOCIATION OF REHABILITATION AGENCIES
NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
NATIONAL EASTER SEAL SOCIETY
NATIONAL MULTIPLE SCLEROSIS SOCIETY
NATIONAL REHABILITATION ASSOCIATION

The National Rehabilitation Caucus (NRC) is comprised of national organizations representing a wide range of health and rehabilitation professionals, consumers and institutional and home and community-based providers of rehabilitation services. As a broad-based and diverse coalition, the NRC has a unique and important perspective on the shortcomings of our current health care system, and its member organizations have a compelling interest in the evolving deliberations on health care reform.

The Caucus advocates reform which incorporates the principle of universal, nondiscriminatory access to a continuum of comprehensive benefits ranging from preventative to continuing care services. Assured appropriateness and quality of care, improved system efficiency and equitable cost-containment should also be central goals of health care reform. Inherent in these principles is, in our view, a need to recognize medical rehabilitation as an essential ingredient of basic, cost-effective, quality health care. While many of the legislative proposals pending before the Congress contain positive and constructive features that are consistent with the principles we believe are necessary to effective reform, others fall short in their efforts to address fundamental health care needs.

MEDICAL REHABILITATION SERVICES

Rehabilitation services are individualized, goal-oriented medical services which are designed to maximize functional ability and promote quality of life and independence for individuals who, whether through accident, illness, congenital condition or birth injury have acquired a temporary or permanent disability. These services are multidisciplinary in nature and are provided by qualified health care professionals including occupational therapists, physical therapists, rehabilitation nurses, physiatrists, respiratory therapists, speech-language pathologists, audiologists, orthotists, prosthetists and suppliers of rehabilitation equipment.

Medical rehabilitation services are available in a variety of delivery settings, depending on diagnostic and therapeutic requirements. These include freestanding rehabilitation hospitals, rehabilitiation units in acute care hospitals, nursing facilities, comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies and clinics, home health agencies and the offices of qualified independent practitioners.

NEED FOR REHABILITATION

It is estimated that over 35 million Americans have conditions that interfere with their life activities and more than 9 million have physical and mental conditions that prevent them from working, attending school or maintaining a household. The numbers of Americans with disabling conditions are projected to increase significantly due to factors such as medical and technological advancements which save and prolong life, and the aging of our population. Medical rehabilitation services have proven to be a necessary and cost-effective treatment for the conditions that can prevent Americans from maximizing their potential.

Persons benefiting from rehabilitation services include, individuals who have sustained a heart attack or stroke; have arthritis, cancer or a neurological disorder; have undergone amputations or joint replacements; have developed sensory deficits and/or chronic

intractable pain; have experienced a traumatic accident or a debilitating illness or suffer from chronic pulmonary disease; and children who are born with or develop physical impairments. Medical rehabilitation speeds recovery, prevents recurrence or rehospitalization and maximizes the restoration of functional capacity. Rehabilitation services are essential to ensure that these individuals can function as independently as possible and return to their homes, communities and jobs.

COST EFFECTIVENESS

Rehabilitation has proved a cost-effective alternative to extended institutional acute care, as a variety of studies have demonstrated. For example, a survey conducted by the Health Insurance Association of America (HIAA) of its member companies found a savings of $11 for every $1 invested in rehabilitation services, and a savings per claimant of between $1,500 and $250,000. Similar results have been demonstrated in studies conducted by insurance and case management companie

Under the current syste n f surance premium costs associated with coverage of medical rehabilitation services a e extremely modest when contrasted with potential cost savings and the enh nced quality of life patients can achieve with the availability of such service For example, according to 1990 figures from Blue Cross-Blue Shield of Massachusetts the cost of full coverage in inpatient and outpatient settings of occupati nal therapy, physical therapy and speech-language pathology services amounted to 1.5 percent of the average individual monthly insurance premium, or $3.75 (Source: Blue Cross and Blue Shield Associat on, Washington, DC/Figures are a composite rate combining all groups).

RECOMMENDATIONS FOR REFORM

The National Rehabilitation Caucus endorses the following principles and recommends that Congress incorporate these elements into any health care reform initiative:

Universal Access/Nondiscrimination

All Americans, regardless of age, income, disability or employment, must have access to a basic package of appropriate, affordable, quality health care. Access should be based on health care need as opposed to employment status or income level. Discriminatory health insurance industry practices should be eliminated. Arbitrary rating and underwriting practices, such as exclusions based on preexisting health conditions and waiting periods, are unfair and particularly discriminate against persons with disabilities. Continuity and portability of coverage should be assured for all Americans.

Comprehensiveness

Health care reform should insure the availability of a full range of services necessary to provide a continuum of quality care, and should provide adequate access to these services in the most appropriate settings. A core health benefits package must include coverage of medical rehabilitation services in hospital and home and community-based settings.* Benefits should also include coverage for items that are critically important to achieving functional independence such as prosthetics, orthotics, durable medical equipment and assistive technology.

Quality/Appropriateness of Care

The promotion of appropriate, quality care is essential to a health care system that values outcomes while containing system costs. A central element of reform should be accelerated efforts to develop research-based, multidisciplinary practice protocols to verify therapeutic effectiveness and provide guidance to practitioners and consumers alike. From the medical rehabilitation perspective, measures of quality and appropriateness should be based upon defined standards of care which incorporate uniform functional assessment and outcomes measures.

The Caucus supports a coordinated health care system that assures individuals the type and level of treatment most appropriate to their medical condition. However, the Caucus is concerned that flaws inherent in many of today's managed care models would be continued and promoted by health reform proposals that mandate managed care. Certain current and contemplated forms of managed care can create disincentives for treating persons with disabilities and other persons suffering from severe disease or injury. Neither managed care nor individual case management should be considered a panacea in the quest for reform of the health care system. Case managers must be trained professionals with a clinical understanding of rehabilitation and the unique health care needs of persons with disabilities to assure appropriate, quality care.

Efficiency and Equity

An efficient and equitable health care system should appropriately distribute resources, as well as responsibility, and must include effective and fair cost-containment mechanisms.

A balanced health care system demands that emphasis and resources be distributed along a continuum of care, beginning with preventive services and including acute care, rehabilitation and continuing care services.

Health care reform must provide incentives to reduce unnecessary or duplicative health care and administrative costs. Cost containment efforts should not be based on inadequate reimbursement for health care providers or limited, non-comprehensive benefit packages. Efforts to control system costs predicated on non-comprehensive benefit packages and insufficient reimbursement for health care providers will not promote system efficiency and will stifle efforts to promote quality care and successful health outcomes for all Americans.

- **Although the Caucus has chosen to reference home and community based care only in relation to recommendations on comprehensiveness, home and community based services are justified in the context of each of our recommendations.**

STATEMENT OF ON LOK, INC.

Mr. Chairman and Members of the Senate Finance Committee: On Lok Senior Health Services and its replication program, Program of All-inclusive Care for the Elderly (PACE) are the only organizations applying managed care concepts to an acute and long-term care service delivery system for frail elderly certified by the state as eligible for nursing home coverage.

According to Robert Kane in his Final Report on the Qualitative Analyses of the Program of All-inclusive Care for the Elderly (PACE),

> The On Lok model is important as the most extensive program of capitated care for elderly persons in need of long-term care. This is a group with high needs and correspondingly high service costs for complete service capitation. The TEFRA HMOs cover primarily basic Medicare services oriented to acute care. The Social Health Maintenance Organizations (S/HMOS) provide a modest long-term care coverage for the deliberately small proportion of their clients needing such care. (page 2)

The concept of PACE began in 1973 when On Lok Senior Health Services opened one of the nation's first adult day centers. By 1979, On Lok was providing comprehensive services which distinguish the PACE model, and by 1983 operated with full risk and fixed monthly capitation payments from Medicare, Medicaid and private funds.

Several pieces of federal legislation have supported the growth of the PACE model: (1) Social Security Amendments of 1983 (P.L. 98–21, §603) authorized On Lok's Medicare (222) and Medicaid (1115) waivers for a three-year demonstration; (2) Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272 §9220) extended On Lok's waivers indefinitely; (3) Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509, §9412) authorized extension of On Lok waivers for up to 10 public or non-profit community based organizations; (4) Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203, §4118) allowed the replication sites to assume financial risk progressively during the demonstration period; (5) Omnibus Budget Reconciliation Act of 1990 (§4744) added five more sites (up to fifteen); created Medicaid-waiver start-up option; and required states to use the same income and assets eligibility rules for PACE enrollees as for nursing home residents.

Currently eight sites are operating under waivers, and others are in various stages of development.

As authorized by federal legislation, each PACE demonstration site must: focus on the nursing home certified population; maintain participants in the community for as long as medically, socially and economically feasible; provide comprehensive medical and supportive services through a multidisciplinary team; be a public or nonprofit organization, and assume financial risk by accepting fixed capitation payments to cover all service needs.

PACE puts together in one organization all medical, restorative, social and supportive care. The service range exceeds traditional Medicare and Medicaid benefits by far, extending from hospital and nursing home care to podiatry, dentistry, grooming, transportation and home-delivered meals.

No matter how costly a PACE participant's care becomes, continued coverage and care are guaranteed for the fixed monthly rate. Services are provided as long as necessary, no artificial benefits limits are imposed, and no additional co-payments or deductibles are required for any needed services.

The PACE multidisciplinary team consists of primary care physician, geriatric nurse practitioner, nurse, social worker, rehabilitation therapists (physical, occupational, speech), recreation therapist, dietitian, health worker and driver. The team assesses each participant's social and medical problems, develops a care plan, directly provides most of the services and manages care by contractors such as medical specialists and hospitals.

Upon enrollment an initial assessment is done, an assessment summary and plan of care developed and sent to the State Medicaid Office for level of care determination. All enrollees must be over 55 years, live in the service area and be eligible for intermediate or skilled nursing care. PACE utilizes the financing principles of HMO for a population that are, by definition, users of services. Case management and assessment are an integral part of service provision and allow for close monitoring and rapid response to changes in health status. PACE programs provide the full range of acute and long-term medical care, health and health-related services needed by a very frail population.

As you review the various health reform proposals, please consider two factors that are essential for the survival of the PACE program.

1. Long-term care and health reform proposals are often in separate bills. Legislation needs to allow for and encourage the consolidation of long-term care with the health benefits and allow such plans to service exclusively special populations such as frail elderly certified for nursing home.

2. To superimpose an assessment and case management agency over PACE would be costly, cumbersome and would lower the quality of care. Legislation is needed to exempt these plans from assessment and case management requirements by a separate case management agency.

Recently introduced legislation, such as H.R. 3535 Roybal, *"The U.S. Health Program Act of 1991"* S. 2571 Mitchell, et al, *"Long-Term Care Family Security Act of 1992"* and H.R. 4848 Waxman and Gephardt, *"Long-Term Care Family Security Act of 1992"* do contain such provisions recognizing the unique nature of PACE.

Additional information about the PACE program is enclosed.

PACE is a viable option. Our hope is that proposed major changes in the health care system will allow the continuation of PACE and not prohibit its development.

Thank you for consideration of my suggestions.

Effective National Health Care Reform Means RETHINKING Long-Term Care

Population pressure mounts...

1990 7 million in need of long-term care

2020 12 million in need of long-term care

The present long-term care system leads to:

- Institutional care
- Discontinuous, duplicated services
- Little control over cost or utilization
- Higher and higher costs

An older person, in failing health, faces:

- Fragmented care
- Repeated, lengthy hospital stays
- Family stress
- Early nursing home placement
- Impoverishment

Two choices for the future...

1. Build 100 nursing home beds each day until the year 2000

✓✓ 2. Support community-based services such as:

✓ **PACE**—*Program of All-inclusive Care for the Elderly*

- ✓ More humane, community-based care
- ✓ Better cost control
- ✓ Greater client and family satisfaction
- ✓ Less expensive care — no deductibles or co-payments

PACE: An Integrated Approach to Care Provision

The PACE model entails fresh ideas for both the delivery and financing of care.

Focus on the Frail Elderly

Only frail elderly persons are enrolled—those who meet their State's Medicaid health standards of eligibility for institutional care. Through PACE, they are able to:

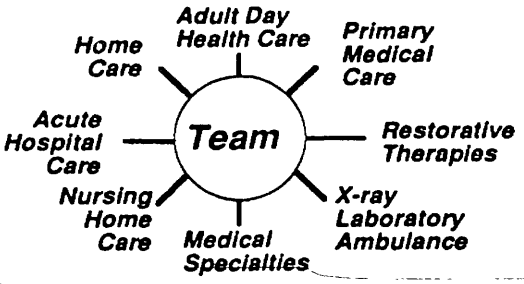
- ✓ remain as healthy as possible at home in their communities
- ✓ maintain their independence, dignity, and quality of life.

All-Inclusive Care

The PACE model offers and manages the full spectrum of health, medical and social services required to keep the frail elderly person as independent as possible. This includes preventive, rehabilitative, curative and supportive services provided in day health centers, homes, hospitals and nursing homes. These services are provided by a team that includes:

- physicians
- nurses
- physical therapists
- recreation therapists
- occupational therapists
- dieticians
- social workers
- home health aides
- drivers

Typically, a frail older person has complex, continually changing medical, functional and psycho-social problems. The PACE professional team has complete flexibility in designing a care plan tailored to the individual's needs.



One-Stop Shopping

All care is provided by one non-profit health care organization, generally in the same setting, a community day health center. The individual and the family are spared from having to negotiate needed services with multiple providers and practitioners.

PACE: A Cost-Conscious Approach to Financing

PACE makes fundamental changes in the financing of health-care services.

Pooling of Health and Long-Term Care Dollars

The current system makes distinctions between funding for "short-term health care" and "long-term care" that are unwieldy and often meaningless when applied to the frail elderly. Setting aside this distinction, **PACE** pools all existing resources—Medicare, Medicaid and private dollars—to achieve maximum efficiency. Currently, special waivers must be obtained to permit this pooling. It is hoped that in the future, the **PACE** model will become an integrated part of government health-care financing.

Incentives for Quality and Cost Control

The **PACE** provider receives a set monthly fee per participant. This "capitation" financing method motivates the program to keep the frail elderly person functional and ambulatory, which in turn keeps the provider's costs low by reducing the need for high-cost institutional care. (By contrast, the "fee-for-service" approach motivates the provision of ever-more services at ever-higher costs. If the patient gets sicker and needs more care, the provider gets more dollars.) With **PACE**, Medicare, Medicaid and/or individuals each pay a fixed monthly premium. This amount is based on the participant's entitlement, not the level of frailty or service utilization.

Assumption of Financial Risk

The organization is responsible for all of the care that participants need; it cannot shift costs back to the public sector. This assumption of financial risk provides an added incentive to keep participants as healthy and ambulatory as possible, while limiting public spending. At the same time, safeguards are in place to assure that "savings" are not achieved through denial of necessary care and services.

Savings to Federal and State Governments

Because **PACE** services are more economical to provide, **PACE** organizations have agreed to accept 95% of the costs experienced by Medicare for a comparable population in the fee-for-service sector. The cost to Medicaid is reduced as well. Where individuals pay a portion, their cost is less than for comparable nursing home care. Savings from reduced usage of costly hospital and nursing home care are plowed back into services which are not ordinarily covered by Medicare and Medicaid—either by type of service or frequency. For example, meals, transportation, non-prescription drugs and physical and occupational therapy.

PACE's Early Returns

The PACE replication's success reflects careful planning and development.

The Prototype

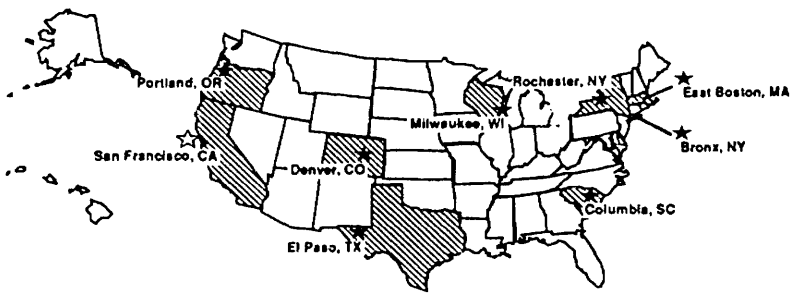
The PACE model was developed by On Lok Senior Health Services in San Francisco. In response to the urgent needs of the community's frail elderly, On Lok's approach evolved over two decades, maturing in the 1980's into a well-defined service and financing system. This fresh model proved so successful that, in 1986, On Lok began working under specific Federal law with other non-profit organizations to replicate the PACE model in other areas of the country, using the *"each one teach one"* approach.

New Sites Nationwide

With the support of the Health Care Financing Administration and the State Medicaid agencies, a select handful of care provider organizations across the country are participating in a program to replicate the PACE model. By early 1992, replication programs were already up and operating at eight sites: Boston, MA; Columbia, SC; Milwaukee, WI; Portland, OR; Denver, CO; El Paso, TX; and The Bronx and Rochester, NY. Others are under development, following a strategy of gradual growth.

These replication programs are critical. The experience gained will allow the refinement of the PACE model to suit diverse communities nationwide.

Several hundred non-profit groups and organizations have expressed interest in sponsoring additional PACE sites. For example, the Boston site has received funding from the State of Massachusetts, the Robert Wood Johnson Foundation and the Boston Foundation to explore further multiple replications in that State.

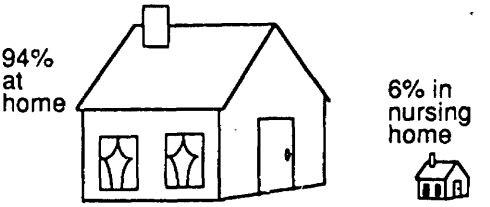


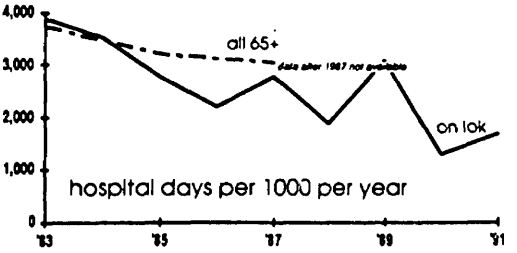
An Exciting Record of Success

The early results from the PACE replication sites show the PACE model of providing care in a community setting is working!

Lower Nursing Home Use

Although every one enrolled in a PACE program is eligible for nursing home care, fewer than 6% actually have to be placed in a nursing home.





Lower Hospital Use

Despite the extreme frailty and advanced age of their participants, PACE sites have progressively reduced the need for hospital care. At On Lok, the prototype, participants use fewer hospital days than the general 65+ population, which includes both healthy and frail elderly.

New Relationships between Medicare and Medicaid

PACE brings the Health Care Financing Administration and the State Medicaid agencies together for efficien. coordination and better care. This cooperation links health and long-term care and results in savings to both.

Quality Care

Most importantly, more and more frail elderly persons are receiving quality care through PACE while maintaining their way of life in their home towns.

Preparing for Nationwide Adoption

Systematic, controlled growth is the strategy of choice to make this new care model available throughout the United States.

Major Change Takes Time

PACE represents a significant departure from the current system's independent and organizational approaches to care. State and federal governments must adopt new methods of reimbursing and regulating care. Health care professionals and providers must master new approaches to providing service. Elderly people and their families must learn about a new alternative.

The Stakes Are High

Any new venture entails risks. Consumers must be protected while providers learn to operate this new, risk-based model. But the potential for gain is enormous. By building the model slowly and carefully, the risks will be minimized and the benefits maximized for everyone.

Careful Development Process

The same careful thinking and planning that went into the replication of the On Lok approach is now being directed toward preparing the PACE model for successful adoption in diverse settings nationwide. The two decades of operating experience acquired by On Lok, and the new data and experience being accumulated by the replication programs, will help greatly in this venture.

Each One Teach One

Using the *"each one teach one"* system, new sites develop with extensive technical assistance from PACE staff who have experience working with the model. Their practical guidance gives new programs the best chance for successful operation and consistently high quality of care.

Challenges Ahead

- ✓ Build consumer and community awareness about PACE
- ✓ Provide hands-on assistance to care teams at new PACE sites
- ✓ Codify quality assurance mechanisms for PACE
- ✓ Obtain reinsurance for PACE provider organizations

PACE: A Public-Private Partnership

PACE thrives on a diverse base of support, including government, foundations, research institutions and community agencies.

Federal and State Government

Health Care Financing Administration
Office of Research and Development
California Department of Health Services
Colorado Department of Social Services
Massachusetts Department of Public Welfare
New York Department of Social Services
Oregon Senior Services Division
South Carolina Finance Commission
Texas Department of Human Services
Wisconsin Bureau of Health Care Financing

Private Foundations

Boston Foundation, Boston, MA
Colorado Trust, Denver, CO
Duke Endowment, Charlotte, NC
Evelyn and Walter Haas, Jr. Fund, San Francisco, CA
Faye McBeath Foundation, Milwaukee, WI
Fred Meyer Charitable Trust, Portland, OR
Henry J. Kaiser Family Foundation, Menlo Park, CA
John A. Hartford Foundation, New York, NY
Koret Foundation, San Francisco, CA
Meadows Foundation, Dallas, TX
Milwaukee Foundation, Milwaukee, WI
New York Community Trust, New York, NY
Presbyterian/St. Luke Community Foundation, Denver, CO
Providence Medical Foundation, Portland, OR
Public Welfare Foundation, Washington, DC
Retirement Research Foundation, Chicago, IL
Robert Wood Johnson Foundation, Princeton, NJ
San Francisco Foundation, San Francisco, CA
United Hospital Fund of New York, New York, NY

Research Institutions

Abt Associates, Inc., Cambridge, MA
Principal Investigator: Laurence Branch, Ph.D.
(Impact Evaluation Contractor)
School of Public Health, University of Minnesota, Minneapolis
Principal Investigator: Robert Kane, M.D., Ph.D.
(Process Evaluation Contractor)

PACE Replication Project

Technical Assistance and Coordination

On Lok, Inc., San Francisco, CA
Executive Director: Marie Louise Ansak
PACE Director: John Shen, Ph.D.

Prototype

On Lok Senior Health Services
1441 Powell Street
San Francisco, CA 94133 (415) 989-2578
Director: Jennie Chin Hansen

Replication Sites

Bienvivir Senior Health Services, Inc.
6000 Welch Street, Suite A-2
El Paso, TX 79905 (915) 779-2555
Executive Director: Rosemary Castillo

Community Care for the Elderly
1845 N. Farwell Ave, Suite 2007
Milwaukee, WI 53202 (414) 276-4357
Executive Director: Kirby Sheaf

Comprehensive Care Management, Beth Abraham Hospital
612 Allerton Avenue
Bronx, NY 10467 (212) 920-5910
Vice President: Susan Aldrich

Elder Service Plan, East Boston Neighborhood Health Center
10 Gove Street
East Boston, MA 02128 (617) 567-5801
Director of Geriatric Services: Jean Masland

Independent Living for Seniors, Rochester General Hospital
355 N. Park Drive
Rochester, NY 14609 (716) 366-2025
Executive Director: Ken Naples

Providence Elder Place, Providence Medical Center
4540 NE Glisan Street
Portland, OR 97213 (503) 230-6591
Executive Director: Nancy Gorshe

Palmetto SeniorCare, Richland Memorial Hospital
2 Richland Medical Park Suite 405
Columbia, SC 29203 (803) 253-4597
Project Director: Judy Baskins

Total Longterm Care, Inc., Presbyterian/St. Luke's Medical Center
1801 East 19th Avenue, #608
Denver, CO 80218 (303) 839-7515
Executive Director: Linda Barley

Sites in Development

Coalition for Elders Independence, Inc., Oakland, CA
Maluhia, Honolulu, HI
Sutter SeniorCare, Sutter Health Services, Sacramento, CA
Umoja Care, Bethel New Life, Inc., Chicago, IL

Public Policy Agenda for PACE

The progress, momentum and broad applicability of the PACE model are already bringing excitement and hope to health care reform deliberations.

But continued s· p ort from key public policy makers is vital. Here's what you can do to help.

- ✓ **Help expand the number of PACE replication sites.** Achieve systematic growth through the "each one teach one" approach of practical guidance and technical assista·ıce
- ✓ Develop a revolving matching loan fund for start-up of PACE sites
- ✓ Support governmental health insurance that integrates health-care and long-term-care programs

A Federal Legislative History: PACE Authorization and Amendments

1983 Social Security amendments authorized On Lok's Medicare and Medicaid demonstration, permitting the first PACE program. (P.L. 98-21, §603)

1985 Consolidated Omnibus Budget Reconciliation Act made On Lok's program permanent. (P.L. 99-272, §9220)

1986 Omnibus Budget Reconciliation Act authorized up to 10 PACE demonstrations. (P.L. 99-509, §9412)

1987 Omnibus Budget Reconciliation Act authorized progressive assumption of financial risk by PACE sites. (P.L. 100-203, §4118)

1990 Omnibus Budget Reconciliation Act increased PACE demonstrations to 15 and equalized Medicaid eligibility rules for PACE enrollees and nursing home residents. (P.L. 101-508, §4744)

Please help us extend this progress as we move through the 1990's!

PACE

On Lok, Inc.
1441 Powell Street
San Francisco, California 94133
415/989-2578, ext. 300

STATEMENT OF SOUTHERN CALIFORNIA EDISON CO.

Mr. Chairman and Members of the Committee: I appreciate the opportunity to submit testimony on the options for controlling our nation's health care expenditures. Southern California Edison is the nation's second-largest electric utility, providing service to ten million people in a 50,000-square-mile territory in Central and Southern California. Edison is heavily involved in both providing and paying for health services for our 55,000 employees, retirees, and their family members. Since 1903 we have operated primary health care services in-house, which today include eight primary care clinics, two first-aid stations, and a large corporate pharmacy. In 1991, there were more than 62,000 patient visits in our clinics and 200,000 prescriptions filled in our pharmacy. We also self-fund and self-administer our own health plans, including the processing of all medical claims.

As a major employer that has assumed a substantial responsibility for the health of its employees, Edison urges the Congress to develop a strong federal initiative to manage the growth in national health care spending. While you may expect a corporation to be motivated to advocate national reform by a failure to control its own costs, Edison's position evolves from our success in managing our health care costs, and the understanding we have gained of the need for national reform.

EDISON'S COST MANAGEMENT EXPERIENCE

The decade of the 1980s was a period of very rapid growth in health care costs for Edison as well as for other employers. In just ten years, our annual spending on health care has grown fivefold—rising from $21 million per year in 1981 to $103 million per year in 1991. During the 1980s our costs were rising at an average rate of 22 percent a year. At that rate of increase, health care costs would have begun to affect Edison's competitive position in an increasingly deregulated utility industry. In 1989, we responded with a major effort to restructure our health care plans.

Our reform was aimed at encouraging our employees to take more responsibility for their health, developing financial incentives for the use of efficient, high quality providers, and managing utilization to minimize unnecessary, inappropriate and harmful health care. That approach has worked very well for us—our long term annual growth rate has now been reduced from 22 percent to about 10–12 percent. Let me detail the components of our reform.

Incentives for Efficient Use of Care

First, we created financial incentives for participants to realistically evaluate their health plan needs and to use health care more efficiently. We have done this through a combination of new options which include our indemnity plan called HealthFlex, self-funded HMOs and health care reimbursement accounts.

HealthFlex offers a choice of three deductible options and minimizes copayments for employees who use our preferred-provided network. For employees who prefer an HMO alternative, our self-funded HMO options provide that delivery alternative while allowing us to include this experience in our health care group insurance risk pool. Employees may now elect to put pre-tax funds in a flexible spending account, which they can use to pay deductibles, copayments or other out-of-pocket portions of their health care bills. This creates new alternatives for employees when considering how to manage their own health care costs. For example, they might select a "rich" option where contributions are required or select a higher deductible option with a lower cost and cover the out-of-pocket expense through their reimbursement account.

A large proportion of our employees have responded to these incentives. To date, 88 percent of Edison employees have enrolled in one of our lower-cost alternatives—either the HealthFlex options (72 percent of employees), or our self-funded HMO options (16 percent of employees). Due to the changes in incentives for employees making health plan selections, we have realigned the risks assumed by the various options and created a more equal distribution of health plan experience. These changes saved $24 million in 1989 through 1991 over the anticipated expenditures.

Management of Health Care Utilization

Second, we focused our utilization management efforts on helping participants get necessary and appropriate care in several key areas: hospitalization, outpatient surgery, mental health services and substance abuse treatments. This works in tandem with our preferred provider network of 7500 physicians and 85 hospitals which we have built by credentialing and monitoring providers to identify those best able to deliver quality services at pre-set rates. We also initiated a five-year effort to phase in managed care and cost sharing features for future retirees. We implemented active management of our inpatient admissions and outpatient services, with financial

incentives to direct plan members to our selected preferred providers for a savings of $42 million over our expected costs for 1989 through 1991.

Incentives to Reduce Health Risks

Third, we created financial incentives to encourage our employees and their spouses to reduce their own health risks. We use two financial incentives: a Preventive Health Account that provides $150 toward the use of preventive services, and a Good Health Rebate that provides cash incentives for participants who are within screening guidelines for five cardiovascular risk factors or who undertake a program to reduce any elevated risk factors. This program has worked well to date—although it is entirely voluntary, we annually screen more than 45 percent of eligible plan participants for the Good Health Rebate. The gains in health status for our employees and the savings for our health plans will come in the future.

Results

In short, at Edison, we set out to involve our employees in the management of our health care costs—and our efforts are paying off. In a three year period—1989 through 1991—we spent approximately $66 million (or 20 percent) less than if we had not implemented these programs. We achieved a high rate of screening, counseling, and behavior change with our preventive health efforts.

Future Directions

We are moving toward the development of a fully integrated "organized delivery system" for our employees. To date, we have contracted with selected providers to deliver quality services at reasonable prices. We have encouraged our employees to take an active role in managing both their own health and health care treatment through a series of financial incentives. We have measured, monitored, and managed the delivery of care in order to enhance our ability to improve the quality of care without raising the price.

Our next step is to strengthen our quality controls, tighten our networks, coordinate care through primary care physicians, and transition into an outcome-managed system. We are moving to establish "seamless" administration of services for all patients, directed by their primary care physicians, with the support of a patient care management team. Our goal is to enhance employees' satisfaction and their incentives to use our networks by increasing our assurance of quality and simplifying the patients' role in using the system.

Nevertheless, we still are dealing with only one aspect of the broader cost-containment problem—creating incentives for efficient utilization of health services. As long as our fragmented system of paying for care continues, the other factors contributing to rising health care costs—the proliferation of technology and capital, the oversupply of specialists, the increasing costs of medical malpractice liability—will continue to be beyond any single corporation's control.

EDISON'S PROPOSAL FOR FEDERAL ACTION

Competing philosophies for solving our nation's health care problems have led to policy gridlock in Washington. While this is not solely the result of a disagreement over how to control costs, the cost containment issues are some of the most difficult. Experts appearing before this committee will argue for pure concepts: creating more price sensitive consumers, managing care, regulating rates, or establishing global budgets. All of them will have sound reasons for contending that one approach or the other—taken in its pure form—will work. And all of the proposals, taken individually, would probably have some effect on costs.

It would be a tragic waste of this nation's resources, however, if we allowed national health expenditures to double while we deliberated on which pure reform approach to adopt. Another decade of debate on how to slow expenditure growth will teach us little new about what will work. A decade from now we will still have to plunge ahead without a perfect solution. The difference will be that we will be starting from a base of $1.6 trillion rather than $800 billion in expenditures.

If there is any lesson to us from the lower health costs of Canada and Europe the lesson is not in how they controlled their costs, but that they acted to control costs, and that they had the courage to act before they had all the answers. These actions alone helped to avoid in Canada and Europe the substantial increases that were characteristic of the American health care system in the 70s and 80s and have now become a permanent part of our cost structure. We cannot turn back the clock and retrieve those lost resources, but we can avoid greater losses in the future.

We believe that a significant reduction in the rate of growth in health costs is too urgently needed and too elusive to lend itself to only a single approach. There

is no need to wait for the right answer. The Congress should combine the best of the tools that have been conceived and attempt them all.

Even before the Congress decides on how to blend competing approaches, it can act to establish the infrastructure for reform that will be needed regardless of the final course adopted. By "infrastructure" we mean the data bases, the information, the local entities, and the capabilities that will have to be in place and functioning before any reform approach can be fully implemented. The immediate enactment of "building blocks" for reform, such as those we specifically recommend below, will give the country a sense of movement on this issue and greatly accelerate the pace of implementation once comprehensive reform is enacted.

Let me elaborate. Edison approaches national cost containment in three parts—restructuring of the health care delivery system in the long-term; significant cost containment measures consistent with these delivery system reforms in the short-term; and, as I mentioned before, the building blocks for reform that could go into effect this year or next.

Delivery System Reform

Our optimal choice is to create a cost-effective delivery system focused on quality. In a perfect world, market concepts would work to drive health care delivery to efficient levels. For this to happen, providers need to have incentives to deliver high quality services at a low cost. These incentives would come through the financial involvement of providers in health care delivery systems that would compete for members (patients) on the basis of quality and cost. The competition would depend on knowledgeable and price sensitive consumers who would intelligently shop for the most efficient and highest quality organizations.

Organized Delivery Systems

In our preferred model, each community would have several large, vertically-integrated, "organized delivery systems" providing, within each one, a full continuum of health care services. Individual consumers (employees) would select the best organized system by comparing each system's publicly disclosed measures of cost and quality for comparable benefit packages. Consumers would be sufficiently knowledgeable to evaluate differences in quality and cost between competing systems. They would be price sensitive by virtue of receiving a fixed benefit amount from their employer and paying all of the cost difference between their chosen package with their own after-tax dollars. With a proper risk-adjustment mechanism to prevent plans from lowering their costs by selecting or attracting only low-risk members, we believe these systems and the providers in them would be motivated to improve quality and lower costs in order to attract more members. One option for reducing the advantages of risk selection would be to pool all employer contributions and distribute risk-adjusted, per-capita payments to the plans on the basis of the demographics of their enrolled population.

One of the most attractive features of this model is its emphasis on improving the quality of medical care. The capacity of organized delivery systems to provide a full continuum of services would enable them to emphasize preventive care where it can be cost effective, to provide services in the most appropriate and least-costly settings, and to maintain continuity of care, resulting in better treatment outcomes. Competitive pressures on the delivery system to excel in the publicly-disclosed quality measures would encourage careful provider selection, rigorous monitoring of practice patterns and patient outcomes, on-going provider training and upgrading of skills, and the use of multi-disciplinary treatment teams and comprehensive case management. Organized delivery systems would develop the data resources and the continuous quality improvement techniques to measure outcomes, identify effective practice patterns, and move the standard toward the optimum level of care.

Obstacles to Organized Delivery Systems

The most significant objections that have been raised to the emergence of this kind of delivery system are that it would limit the physician's freedom to practice. For many physicians today, however, the "freedom to practice" is fast becoming an illusion. Independent practitioners are dealing with multiple insurers and a variety of external claims and practice review requirements that subject their medical judgment to the scrutiny of anonymous third-parties. Organized delivery systems would offer providers a significant reduction in the "hassle factor." Because physicians are at financial risk in these systems, their judgments about cost and effectiveness of treatment affect their own profitability, and thus remain their own and their colleagues' responsibility. Organized delivery systems offer providers the additional benefit of the opportunity to work with and learn from multidisciplinary teams of colleagues.

Employee resistance to restriction in their choice of providers is another objection to these systems. In fact, the trend in networks has moved away from the "closed panel" or restricted choice models by permitting members to elect to use non-participating physicians at the "point-of-service." The provision of a "point-of-service" option is necessitated by a general lack of trust of the quality of the provider networks and the need to overcome employee resistance by providing reassurance that if something serious happens they can go "out-of-network." Organized delivery systems would provide members this reassurance through an entirely different approach—the broadly publicized quality standards documenting the excellence achieved by their own organized delivery system. We believe our employees would be more than willing to exchange their freedom of choice of providers for the opportunity to participate in a high quality system of care. And in fact, we plan to test this idea over the next few years.

Incentives for the Development of Organized Delivery Systems

We believe federal policy should encourage the growth and eventual dominance of organized delivery systems. To this end, we recommend a number of legislative provisions. First, there should be a definition of organized delivery systems that distinguishes these quality-based systems from the average managed care plan or HMO of today. This might be accomplished through the adoption of federal standards and the certification of organized delivery systems—not unlike the standards the Chairman and this committee proposed in S. 1872 and the Senate version of H.R. 4210 for managed care plans. Federal standards would address provider selection, monitoring and outcomes measurement, practice standards, physician education and recertification, continuous quality improvement, public disclosure of cost and quality measures, standard benefit packages, and members protections (such as the right to appeal decisions). It is important in developing this definition to recognize that organized delivery systems are intended to achieve a higher standard of quality. The definition should not be broadened to accommodate existing federally-certified HMOs.

There should also be a financial incentive for employers to select organized delivery systems and for employees to enroll in them. The government might provide financial support for the start-up costs and quality assurance systems development associated with organized delivery systems. Medicare and Medicaid might participate on terms that are more favorable to the organized delivery systems than the current Medicare risk contracts. If limits on the tax exclusion of health insurance are enacted in the future, organized delivery system benefits might be the standard for the full exclusion.

Finally, the government should help in educating consumers about the value of selecting organized delivery systems. Better consumer education would go hand-in-hand with federal certification to reassure employees about the quality of these systems.

Short-term Cost Containment Measures

Our vision of organized care systems is a vision for the long run. While we would prefer to rely on this kind of market dynamic to slow the growth in national health care expenditures, we do not expect to see these kinds of systems develop rapidly enough to prevent a doubling of health expenditures in this decade.

As a result, we firmly believe more immediate action is needed within the next few years to slow expenditure growth. Our short-term strategy is intended to have a direct effect on the major factors raising health care costs without interfering with the movement toward organized delivery systems.

An End to Cost Shifting

Cost shifting is a reflection of the ability of providers to resist pressures from payors to provide care more efficiently. Providers compensate for reduced revenues from one group of payors by raising charges to another group. As government payments are reduced, providers maintain their high costs and shift their losses to the smallest private payors. This cost shift raises health insurance premiums for small groups and contributes to the growing number of persons no longer covered by health insurance.

Inadequate Medicare and Medicaid payments are one major source of the cost-shift. Edison believes the Congress must address the urgent need to raise additional revenues from broad-based sources to pay fairly for Medicaid and Medicare beneficiaries and reduce the amount of cost-shifting.

Merely paying more for government beneficiaries would only raise total expenditures unless it is done in the context of a system to moderate payments generally. Edison believes that the federal government should create a system of all-payor rate negotiation to ensure that every health care payor, no matter how small, can benefit

from the rates negotiated by the largest purchasers. This negotiation can be conducted at the local level and can involve different rates for different providers—in much the same way as managed care entities today negotiate rates with providers.

Most importantly, these negotiated rates can help to encourage more cost-effective delivery of health care. And where payment methods already encourage cost-effective care, such as in the risk-based payments for organized delivery systems, the payors could be exempt from the all-payor rates. Eventually, as organized delivery systems predominate, rate negotiation would disappear along with the fee-for-service payment system.

A Limit to National Expenditures

While all-payor rates may eliminate inequities and stabilize financing, they do not prevent excessive utilization of health services from driving-up national expenditures. To develop certainty and predictability in health care financing, Edison believes an overall limit should be set on increases in total expenditures—a national expenditure target. A national target will give us all a yardstick for measuring our progress toward cost containment, and it will provide some modest assurance to employers that there is some limit to their health care spending.

A Rational Allocation of Resources

In the end, however, much of this effort will be futile unless we also constrain the endlessly increasing supply of health care. Excess supply in the health care industry increases prices rather than reduces them, as it would in most other industries. While recent Heath Care Financing Administration (HCFA) efforts to limit payments for new capital and technology under Medicare are helpful, they should not be confined to the government. All payors need to be involved in the effort to eliminate unused hospital beds, encourage fewer specialty physicians, and slow the spread of expensive technologies, if these efforts are to be truly effective.

Greater Value from Health Care Spending

Finally, we need to be assured that we are getting a dollar's worth of health care for a dollar's worth of cost. Edison is willing to manage its health programs to avoid unnecessary and inappropriate care and encourage the highest quality of medical care. We need the leadership of the federal government to generously fund outcomes research, encourage the development of medical practice standards, and ensure that payors remain free to identify, contract with, and reward providers who can deliver appropriate, high quality medical care.

Immediate "Building Blocks" for Reform

Even if the Congress were ready to enact a significant cost containment plan today, there is little chance that it could have much of an effect in the next few years. Before any strategy can work, it would need better data than we have now, some structure of local, state, and national bodies to oversee its implementation, and some common process for managing the emergence of new technologies. In short, there will need to be a health cost containment infrastructure in place for national reform to work.

We have a choice. Congress can wait to enact comprehensive reform and then wait again while the infrastructure is developed; or Congress can develop the infrastructure now and have it up and running when comprehensive reform is enacted.

Edison would like to commend the Chairman and this committee for having included a number of provisions to develop a reform infrastructure in S. 1872, and in the Senate version of H.R. 4210—the tax legislation vetoed by the President.

Edison has in the past recommended the enactment of six "building blocks" of federal policy that would serve as a foundation for comprehensive reform. These are consistent with the cost containment provisions in H.R. 4210. They are:

(1) A National Council on Health Care and state and local councils that would monitor national and state-level health care expenditures, propose non-enforceable expenditure targets, report annually on causes of expenditure growth and proposed solutions, and eventually become the entities conducting payment negotiations;

(2) A single national health care claim form, such as the HCFA 1500, that would be used by all providers and third-party payors, could be entered into an electronic claims system, and could generate statistical records for a national health care data base;

(3) A national data base of significant provider capital purchases to generate statistics on the allocation of new capital and technology;

(4) A national technology assessment agency with responsibility for determining the efficacy of both new and existing procedures and equipment, and publishing coverage guidelines for payors;

(5) Medicare/Medicaid waivers to permit states to initiate new payment methods that could eliminate cost shifting and improve access for the uninsured, and, over time, would incorporate Medicare and Medicaid payments; and
(6) Waivers of federal antitrust restrictions on community multipayor consortiums to permit group negotiations with physician and hospital groups.

We believe these "building blocks" could be implemented this year without great expense, and would lay the foundation for developing the comprehensive reform we hope will follow.

CONCLUSION

In conclusion, it is frequently said that Washington's health care reform gridlock reflects a lack of public consensus on how to restructure our health care financing. The many public opinion polls on this subject seem to reinforce the idea of a confused public—there are about equal numbers of citizens who prefer a single-payor system, support "play-or-pay," and favor incremental reform. Legislation cannot advance, it is said, as long as there is this kind of public uncertainty.

While the public may be uncertain about how to restructure the financing and administration of the system, we believe most Americans are in agreement on the need for cost containment. When asked how to control costs, most Americans point to the need to eliminate wasted services and to the potential for a more efficient health care delivery system providing a higher quality of medical care. No matter what expediencies we must adopt to bring expenditure growth under control, cost containment will ultimately be achieved through incentives that effectively change provider behavior and improve the quality of care.

We believe there is a convergence of views between payors and providers recognizing both the need and the feasibility to move toward a quality-based health care delivery system with the incentives to both encourage consumers to use care more wisely and physicians to provide care more efficiently. Edison's transition to a "third generation" of managed care is already a step toward this future. Other kinds of managed care entities are moving in this direction as well. This is a road this country has already begun to travel, and with the help of the Congress could travel at a more rapid pace.

The transformation of health care delivery, however, will take time. Time during which national health expenditures will continue to grow rapidly and during which the base for health care costs will expand. To prevent this continued expansion in the short-term there must be visible limits placed on the resources going into the system. Edison believes these limits can be specified at the federal level, but implemented at the local level in the form of negotiated all-payor rates, overall expenditure targets, and careful resource allocation.

We believe the first order of business, and the simplest, for the Congress should be to establish the infrastructure for health care reform. Immediate legislation to implement federal, state and local health care councils, to develop necessary data resources, enhance technology assessment, and provide specific waivers for payment consortia would give the nation a positive signal, provide the needed "building blocks" for reform, and shorten the implementation time once real reform is enacted.

Progress of any kind, at this point, would be welcome. We believe Americans are ready for a national solution to the health care problem and are awaiting a sign from Washington. Enacting the "building blocks" is a relatively painless way to provide momentum for reform and pave the way for a future in which better managed care will simply mean better health care for all Americans.

○

ISBN 0-16-039538-0