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EFFECT OF HEALTH CARE COSTS ON THE ECONOMY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

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COMMUNICATION

EFFECT OF HEALTH CARE COSTS ON THE ECONOMY

MONDAY, MAY 18, 1992

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:02 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: Senators Durenberger and Hatch.

[The press release announcing the hearing follows:]

[Press Release No H–25, May 12, 1992]

SUBCOMMITTEE TO EXPLORE EFFECT OF HEALTH COSTS ON ECONOMY; HEALTH CARE SYSTEM IN A CRISIS, RIEGLE SAYS

WASHINGTON, DC—Senator Donald W. Riegle Jr., Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, Tuesday announced a hearing on the costs of America's health care crisis and its impact on the economy.

The hearing will be at *10 a.m. Monday, May 18, 1992* in Room SD–215 of the Dirksen Senate Office Building.

"America's health care system is in crisis. We spend more than $800 billion on health care annually, about $2.2 billion a day. These costs are hurting American businesses, workers and our economy overall," Riegle (D., Michigan) said.

"I am holding this hearing to examine the adverse impact that high health care costs are having on our economy. This is another compelling reason for moving forward on a comprehensive health care reform bill," Riegle said.

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

Senator RIEGLE. The hearing will come to order. Let me welcome all those in attendance this morning. Today we are going to be examining a truly vital issue to our country, namely, the impact of high health care costs on our economy.

In order to do that, we are going to be hearing from national experts on this issue. We will be hearing from leaders of labor organizations, from specific businesses, and from industries as well.

The hearing today will explore the problems that employers are facing with high health care costs and the impact that that is having on American workers and consumers, and also the ability of our companies and our workers to compete effectively, both here in the United States and overseas.

This hearing and other Finance Subcommittee hearings that are planned will complement the series of hearings that Senator Bentsen is also holding on comprehensive reform.

America's health care crisis is part of a larger problem of a shrinking American middle class where our people have less and less economic power to meet their basic needs.

In the area of health care, we spend more than $800 billion a year as a country on health care, or a figure of about $2.2 billion each day.

The health care costs per employee for businesses has risen very sharply. Back in 1985, on average, it was running about $1,750 a year. But, by this year, 1992, it will have jumped from that $1,750 a year to a figure greater than $4,000 a year.

And a family's out-of-pocket costs, which were running at about $1,700 a year in 1980, have risen now to something over $4,300 if we use 1991 figures.

Clearly, these astronomical increases in health care costs are crushing American families, crushing businesses, crushing workers, and, in fact, our overall economy.

At the same time, there are over 35 million Americans who have no health insurance at all, and at least another million are expected to lose the health care coverage they do have this year alone. They are getting squeezed out. In my home State of Michigan, there are close to 1 million people who are uninsured, including 300,000 of whom are children.

Now, companies that provide health insurance to their employees are also paying indirectly for the medical care of uninsured people and people on Medicare and Medicaid.

This is through the whole process of cost shifting, where the costs of uncompensated health care are shifted over to what are called the private payers, those with health insurance. And that has sharply increased the cost of private health insurance coverage. We are going to hear from an expert on that subject here this morning.

In the automobile industry, for U.S. car makers, the average cost per car—or per vehicle, I should say, because it could be cars, or trucks, or other vehicles—for providing health care benefits was running at about $1,100 per vehicle in 1990. These costs have continued to go up.

When you compare that to what is the cost picture for foreign competition, foreign companies producing vehicles in other countries where they have national health insurance systems in place, their health costs are far less and it creates about a $500 per car, or per vehicle disadvantage attaching to American vehicles. It is much higher in the instances of some particular ones.

To just give a measure of the magnitude of health care costs for one company, the largest company in our country, namely, General Motors Corp., last year was the largest private purchaser of health care anywhere in the United States.

They spent almost $3.4 billion last year on health care for their employees and provided coverage to about 2 million American citizens. So, in that instance, as in the instance of others, including Chrysler which testifies later today, the huge differential in cost compared to our international competitors is having a devastating

impact on America industry. We see it, in one instance, in the domestic auto industry, but it is true across the board.

Ultimately, high health care costs for American businesses affect Americans and their families in many ways, including higher product prices, lower wages, and less job opportunity.

In addition, we are seeing higher co-payments and reductions in the scope of medical coverage. It is a vicious cycle, and it is out of control. And that is why we must enact comprehensive health care reform to control these costs and bring health insurance coverage within the financial reach of every citizen and family in our country.

Now, the bill called HealthAmerica that I introduced with Senators Mitchell, Kennedy, and Rockefeller in June of last year, would systematically overhaul the health care system in our country.

HealthAmerica builds on and preserve the strength of the current private and public system of health care, which, once one is able to get into the system, generally provides high quality care.

HealthAmerica would help American businesses in several different ways. The bill would reduce the cost of uncompensated care that is currently shifted to business, all of which adds about 30 percent to the average hospital bill of each patient.

Businesses would also be better able to help manage health care costs of their plans by participating in a National Health Expenditure Board and State Consortia.

Under this system, businesses, working together, would have increased bargaining power with providers. And, in turn, we think that would encourage more efficient delivery of health care services.

We would also reduce overall administrative costs by establishing a single, uniform billing form and streamlining and computerizing the billing process.

We would implement practice guidelines to determine appropriateness of service, encourage the use of more efficient managed care systems, and otherwise reduce unnecessary care.

These and other cost-saving provisions are estimated by outside experts to be able to save us about $90 billion over a 5-year time period.

Now, the Senate is moving forward on developing a consensus on national health care reform. In fact, a version of HealthAmerica was marked up in the Labor Committee and was reported out favorably.

We are working with other members to develop a consensus on reform measures using HealthAmerica as a starting point. A common goal we share is to control skyrocketing health care costs and provide guaranteed coverage to all Americans at price levels that they can afford.

So, I very much look forward to working with other members of the committee to achieve these very important common goals.

Let me now invite to the witness table our first witness today, who is Mr. John J. Sweeney, who is the international president of the Service Employees International Union, the AFL–CIO, based here in Washington.

I am especially pleased that Mr. Sweeney can join us here today. You have given great leadership to this issue. You understand it, I think, as clearly as anybody, because of the vast number of the employees that you represent who are coping with this problem all across the country.

I might say, as I have been travelling around Michigan, I have been talking with a number of workers in the State. I have talked with a number of service employees.

And in almost every situation they tell me that the pressure, negotiating time and otherwise, to be able to maintain health care coverage or to be able to pay the costs that they are facing is just stressing them to the point where they just feel like they are sliding backwards.

So, we would be very pleased to make your statement a part of the record, and we would like your testimony at this time.

STATEMENT OF JOHN J. SWEENEY, INTERNATIONAL PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL, AFL-CIO, WASHINGTON, DC

Mr. SWEENEY. Thank you very much, Senator Riegle. I am John Sweeney, president of the Service Employees International Union.

We represent over 1 million members who are employed as janitors, nurse aids, clerical workers, and other service workers. I am also chair of the AFL–CIO's health care committee.

Mr. Chairman, I welcome the opportunity to present to you and to the members of this committee the worker's perspective on the health care crisis confronting our Nation.

In all of the years I have been with the labor movement, I have never seen a bargaining issue more difficult than health care is today, nor witnessed such anxiety, which you spoke about earlier, among workers over their benefits.

Each time we sit down to bargain a new contract, it becomes increasingly clear that health costs have gotten too far out of control for us to solve this crisis at the bargaining table.

Despite the recent emphasis on cost containment strategies, health care costs have continued to rise at exponential rates with employer costs running two to four times general inflation.

As a result, well-meaning employers and unions are reaching bargaining stalemates over the issue of who will pay the ever-growing health insurance bills. All too often, union members are left with a choice between cut-backs in their health coverage or foregoing any wage increase.

Not surprisingly, health benefits have now become a major issue in 78 percent of all strike activity. That number is sure to grow, for we are told that by the turn of the century, the cost of insuring one employee for 1 year will reach between $20,000 and $22,000.

The urgency of our health care problems demands that we enact national health reform legislation for working Americans now.

As horrendous as the situation is for the 37 million people who have been without health coverage for some time, our members believe they are just one insurance premium increase, or one serious illness away from the same fate. And they have every reason to be concerned.

Let me share with you the results of a recent survey of health plans that cover SEIU members in both public and private sector employment. It shows that premiums for family coverage have nearly doubled in just 4 years, from $2,600 in 1987, to $5,000 in 1991.

This is money that could have gone into the family budget. That 100-percent increase in employer costs is equivalent to a 10-percent wage increase that our members will never see.

Aside from the foregone wages, our workers have had to pick up a larger share of the premium, as well. Over this 4-year period, the employee contribution towards the total premium increased nearly 200 percent; double the increase for employers. And, of course, premium payments represent only part of a worker's total health care bill.

Workers also have to meet their deductibles, as well as foot the bill for co-payments on physicians visits, prescription drugs, and hospital stays. Taken together, these represent a worker's maximum out-of-pocket liability for health care costs.

The SEIU survey showed that the average maximum out-of-pocket liability of our members rose by almost 50 percent in the past 2 years. This means that even though they have insurance, lower wage workers could spend up to 20 percent of their after-tax income on health care.

Every way we look at it, the outcome is the same. Health care costs have now become an important factor in the steady erosion of middle-class living standards.

Here are some specific examples from a couple of SEIU Locals. In Michigan, your home State, SEIU Local 31–M represents workers employed by the State Employment Services Commission.

In 1987, annual premiums for our members covered under the State plan amounted to $3,700 for family coverage. By 1991, these premiums had jumped to over $7,200.

To try to combat these huge cost increases, our SEIU Locals in Michigan have formed a task force with the Governor's office to study health care reform options.

Sally Cummings, an SEIU member from Freemont, MI, is a victim of the rising health care costs. Sally works as a certified nurse's aid at the Meadows Nursing Home in Freemont. She earns $6 an hour and, along with her husband, Olan, had a total family income of around $18,000 in 1991. As an employee at Meadows, Sally is covered by Blue Cross/Blue Shield.

Tragically, her husband does not receive health care insurance through his job as a tractor mechanic. Up to a year ago, Sally and Olan were doing fine through their income from both jobs and from the 10-acre hog farm they owned and worked.

They had lived on the farm for 8 years and were raising a grandson, Michael Calvert, who was 5 years old. Sally had looked into adding Olan and Michael to her health insurance policy, but the premium for dependent care was $208 per month, and the family could not afford it.

That year, at the age of 52, Sally's husband got pneumonia and had to be hospitalized. The doctor said that Olan came within 12 hours of death. By the time the illness was past, the hospital bills were in the thousands. Sally and Olan were forced into bankruptcy

by the hospital bills. They lost the farm. Their credit is ruined and they have been forced to start all over.

Sally and Olan's tragedy is the worry of millions of Americans. And there are millions of horror stories out there. We see them in our SEIU Locals, as do other unions in their locals all across the country; similar stories, and they all point to the same conclusion: voluntary cost containment measures simply will not do the job.

Individually, companies and unions have done what they can to control and manage health costs, but it has not been enough to protect either the living standards of workers, or the bottom lines of businesses.

A dozen States have now tried a coordinated, voluntary strategy for holding down costs and extending access to care through the use of tax credits and low-cost plans.

Minuscule gains in coverage have been swamped by the rising tide of uninsured and exploding costs. We must be realistic about incremental reform. A decade of incremental steps has not moved us closer to a resolution of the health care crisis.

In particular, insurance reforms cannot make health insurance accessible and affordable, unless they are enacted as part of a comprehensive reform method that controls costs and guarantees coverage.

If changes to the small group insurance market similar to those in S. 1872, are enacted without cost containment, three small groups will see their rates go up for each group that receives any reduction.

Many of the small groups will experience an increase of 10–20 percent. Unquestionably, it would be more beneficial to the small group purchasing community, as well as all others in the health care system, that nothing be done rather than subject an already ailing market to the effects of such ill-conceived and harmful legislation.

Again, incremental policy changes make sense only as building blocks in a comprehensive strategy, and we cannot hope to solve the problem city by city, or State by State. And that is why our members and the members of other unions are pressing for national action on comprehensive health reform in 1992. Thank you very much.

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

Senator RIEGLE. Thank you very much. Before we proceed with the questioning, let me ask if Senator Hatch if he has any opening comments at this time.

Senator HATCH. Thank you, Mr. Chairman. I do not. I am just happy to be here as long as I can. Mr. Sweeney, welcome to the committee.

Mr. SWEENEY. Thank you.

Senator HATCH. I appreciate your testimony and appreciate your coming before the committee. And I thank you, Mr. Chairman, for holding these hearings.

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

Senator RIEGLE. Thank you, Senator Hatch. President Sweeney, how many members, in rough numbers, do you now have in the Service Employees International Union?

Mr. SWEENEY. Just past a million members. We have 1 million, 3,000.

Senator RIEGLE. A million. You are over a million members. Is there any other affiliated union within the AFL–CIO that has more members?

Mr. SWEENEY. Yes.

Senator RIEGLE. Who?

Mr. SWEENEY. The teamsters, the AFSCME, and the Food and Commercial workers.

Senator RIEGLE. So, you would rank about fourth, but you would be right up there at the top in terms of the scale of the number of workers that you represent.

Mr. SWEENEY. That is right.

Senator RIEGLE. Now, you would think on the face of it that if you represent a labor organization with over a million members affiliated with it, as you do, that that would give you, it would seem, quite a bit of bargaining power. In other words, that is a large cross-affiliated group.

But what I hear you saying is, that even with a million members, if you had 2 million or 5 million, that the problems that are out there, the nature of the way this system is working in such a perverse and harmful way, that the size of your membership does not, in any measure, really give you the strength or the power to be able to confront this problem. The problem is just too big for even a huge organization like yours. Am I correct in concluding that?

Mr. SWEENEY. Yes, you are correct. The problem is horrendous and too big for any one employer or any one union to solve. In your opening statement, the story on General Motors is so true. And it is also a problem that no individual State or city can solve by themselves. It requires national action.

Senator RIEGLE. Now, if we were to add up the entire organized labor movement, if you take these other large international unions that have membership above a million members, and the broad membership of the AFL–CIO as a large umbrella organization, can you tell me in rough numbers how many millions of members there would now be within all of the affiliated unions under the AFL–CIO?

Mr. SWEENEY. Under the AFL–CIO there are about 14.5 million.

Senator RIEGLE. 14.5 million. So, it is also accurate, is it not, that even a group that large, under the broad banner of the AFL–CIO, is not strong enough or has the power in and of itself to take and deal with these out-of-control health care costs that are affecting virtually ever citizen, and certainly ever member in any organized union in this country.

Mr. SWEENEY. That is right.

Senator RIEGLE. I think it starts to illustrate importantly that this is truly a national problem. If you take all of the workers today who are not part of a labor organization and who, in a sense, do not have the cross-affiliation with others, say, the Service Employees.

A Service Employee, when they are involved in a negotiation in a bargaining session with a particular employee, at least they have the strength of a national organization that is a million strong.

And so, that provides a certain amount of strength and negotiating leverage and professional help at the bargaining table, and so forth.

If you think of all of the people who are outside of organized labor—which is most of the national work force—who, in a sense, are not able to bargain as part of a larger group, they have even less ability, when wages and benefits are set, to be able to, in a sense, fight for themselves or to try to get reasonable outcomes with respect to health care coverage.

And, in fact, what we are finding in more and more cases, both in places where there are no labor unions, and even where there are, that health care coverage is shrinking. In some cases, it is disappearing altogether.

I mean, I have talked with a vast number of small business people in Michigan just in recent months who do not have a union-affiliated work force. They have had to discontinue health care coverage for their employees; get rid of it altogether.

Some to such an extreme that even the business owner has had to surrender the health insurance coverage that he or she has had even for themselves as the person principally responsible for maintaining and guiding the business. So, I think for anyone to imagine that somehow or another any individual by themselves, any group, large or small, by itself, is going to be able to take and deal effectively with this problem or overpower this problem is just not possible.

Even a group as large as the entire organized labor movement or a company as big as General Motors, the biggest company in our country, is finding that it is largely powerless to really deal with these skyrocketing health insurance costs and the fact that it is creating terrible burdens, both for employees, as well as for the companies involved.

You have had some experience before in terms of an effort to try to develop some kind of a board or some kind of a group that would sit down together to try to work out a schedule of health care costs. We have within our HealthAmerica bill the establishment of a National Health Expenditure Board. This board would convene, at still a higher level and with more equal power on both sides of the table, the providers of health care services on the one side and the users of health care services—which would be your workers and everybody else in the country that consumes health care services—with the government as part of that—to see if we can not, at that level, work out some structure of cost control that can arrest this enormous upward spiral in cost.

I know that within the labor movement there has been an effort to try to do that where that has been possible in individual cases.

But what do you think about the value of having that kind of a working model established at the Federal level to try to bring to bear enough strength around a table of that kind so that we can really address these spiraling health care costs and bring them under some measure of control?

Mr. SWEENEY. We would favor that kind of an approach as a part of solving or addressing the cost crisis that we have. We think that all of the principal players have to be at the same table, so to speak, in terms of addressing costs and in terms of finding ways to reduce the cost of health care. And the provision in the leadership bill is, we think, an approach that should be a part of any cost containment program.

Now, just one other thing, and then I want to yield to my colleagues. In the Michigan case that you described to us about Sally Cummings, who was a member of your Service Employees Union, and she had health insurance coverage, but her husband did not, though he also worked. He did not have it, and they did not have enough money to afford to cover him with a separate policy. He got sick, and they lost everything.

That case is all too familiar. I mean, as tragic as it is, it is being repeated all over this country every single day in a case like this where you have got two wage earners, and maybe one is covered where the other is not.

What kind of a burden does this create for your labor organization when you are negotiating contracts, and what are the kinds of trade-offs that arise when a question comes up like this as to whether or not there is going to be coverage provided for the members of a worker's family?

Mr. SWEENEY. Well, the trade-offs or the initiatives that have been taken in terms of voluntary cost containment in various negotiations that we have had were temporarily successful, but, over the long range, did not really have a substantial effect on the cost. The costs continued to accelerate.

Workers are being asked more and more to share the burden in terms of higher deductibles, co-pays, and out-of-pocket expenses. Where employers are able to provide for the increased cost of the increased premiums, it has had an affect on wage increases or other benefits.

In some cases it has also had an effect on pension programs, as well. So, there are thousands and thousands of different situations, but all are a result of the cost crisis that we see in our health care system.

Senator RIEGLE. So, it is fair to say that in many situations because the health care costs have been skyrocketing and are out of control, that in order for an employee to maintain some semblance of health insurance coverage they have had to forego other things.

They have either had to forego maybe establishing a pension or putting an adequate amount into the pension so they will have a decent retirement income, they have had to forego wages, even if the cost of living has been going up and the real value of their income has been dropping.

They may very well have had to forego any adjustment in their take-home pay in order to try to keep the health insurance intact. You are seeing that, I take it.

Mr. SWEENEY. And they also have had to reduce their health care benefits.

Senator RIEGLE. And, in addition, even have less health care coverage. So, they have had to sacrifice on all three fronts.

Mr. SWEENEY. Right.

Senator RIEGLE. I think it is very important that the public understand the nature of what is happening here. You have a group of workers who actually have some additional muscle at the table. I mean, they are part of a large, national organization, they have skilled professional people helping them in those negotiations, such as yourself and your colleagues. And even with that additional bargaining strength, if you will, they are finding that they are still sliding backward because of the enormous pressure of this out-of-control health care cost system. Is that correct?

Mr. SWEENEY. That is correct. It is far beyond any of our individual organizational controls.

Senator RIEGLE. I want to show you one other illustration that was in a newspaper, The Detroit News late last year. This is a story about a single mother, a woman named Cynthia Fyfe. This is her little 6-year-old son, Anthony, here in the picture with her. It describes her story, where she works, she earns a modest income. They live in a trailer park because that is the extent of what they can afford.

And, while she has modest health insurance coverage through her work place, it does not provide any health insurance coverage for her son.

So, in order for her to buy a health insurance policy to cover him should he get sick would cost her about $300 a month. And, of course, she is not earning enough money to be able to even think about buying a policy for him.

So, you have this situation: working parent, caring for a 6-year-old son, in this case, and he has absolutely no health insurance today in our system. He is one of about 300,000 children in Michigan, and it is as if he does not matter.

It is as if the country is in a sense saying, we have got a lot of things we are interested in, but we are not interested enough in you and your future to see to it that you have health care coverage.

And it is so much the pattern today of working families that even if one person in the family has coverage, like the case you cited here of Sally Cummings, the fact is, her husband had no insurance.

He was the one that got sick, and the bills not only bankrupted them, but they had to sell the small farm that they had in Michigan. This is the other part of the problem that I think we can solve if we can get the costs under some semblance of control.

At the same time, we can work on a coverage plan to try to bring all of our people in. I mean, the notion that a little 6-year-old boy like this in America does not have any health insurance coverage today, when every 6-year-old child in virtually every other industrial country in the world today has coverage, that just is unacceptable. To me, that is sort of a crime against the future.

If this little fellow gets appendicitis tonight and his mother is frightened to death as to what the problem is, but she delays taking him to the hospital because she does not have any health insurance coverage for him, he may or may not survive.

There are lots of cases of people who do not survive because they hold off going because they do not have health insurance. We can solve that problem.

Mr. SWEENEY. There is no question about it. And comprehensive reform not only must address the cost issue, but has to address access and quality.

Senator RIEGLE. Senator Durenberger has joined us. Senator Durenberger, did you have an opening comment that you wanted to make before we go to questions with Senator Hatch?

Senator Durenberger. No. I will defer to my colleague.

Senator RIEGLE. Very good. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman. Mr. Sweeney, welcome to the committee. We appreciate having you here and appreciate your testimony.

Mr. SWEENEY. Thank you, Senator.

Senator HATCH. You have spoken sternly against "voluntary" cost containment measures in your testimony.

At a recent Finance Committee hearing, Karen Davis stated that health insurance currently accounts for about 12 percent of the employer's payroll. Now, she predicted that this would rise to 23 percent by the year 2000. That is, it would nearly double within 8 years.

Now, the bill introduced by Senators Mitchell and Kennedy and reported by my other committee, the Labor and Human Resources Committee, requires that 7 percent of payroll tax to be paid by an employer, unless an employer has a health benefits plan that meets certain requirements.

Now, given the difference in cost to the employer—7 percent versus at least 12 percent—why would not an employer simply terminate his plan and enroll his employees into the public plan?

Mr. SWEENEY. We think that many employers may do just what you are saying.

Senator HATCH. I do, too. What effect, in your estimation, would this "play-or-pay" mechanism have on collectively bargained health plans?

Mr. SWEENEY. That would be a subject for individual negotiations. Plans vary so much from industry to industry. They would have to individually negotiate what benefits might be provided in addition to those mandated or stipulated in the government plan.

Senator HATCH. Is it not possible, Mr. Sweeney, that 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 benefit package goes on the table. Is that not going to be more likely?

Mr. SWEENEY. It remains to be seen. The fact of the matter is that every employer and every employee organization recognizes that there is a national health crisis, and we have to have the political will to find the solution for it.

There are going to be individual situations and circumstances that are going to have to be dealt with. But the overriding national problem is the health crisis.

Senator HATCH. Well, union negotiated health plans tend to be among the more comprehensive, and, therefore, the more expensive employee health plans. Employers, however, under our tax rules, are able to write off the entire cost of those premiums.

Moreover, those companies who continue to maintain attractive health plans often have a competitive advantage when it comes to hiring or retaining their workers.

How do you respond to the argument that both the union and the employer are being subsidized through the Tax Code to provide for overly-generous health benefit plans?

Mr. SWEENEY. Well, I think that the fact that employers are providing very good health plans—they are paying double in terms of providing for dependents and the spouse of their workers who may be in uncovered employment, and they are subsidizing those employers as well as sharing in the public cost through their own taxes.

So, I think that the fact of the 37 million, or 36 million—or whatever number you want to use—of those without access to health care, reliable sources say that two-thirds of those are workers and their dependents working in uncovered employment. Every worker in this country should have a basic health plan. Every resident of this country should be covered with a basic health plan.

Senator HATCH. Now, you state in your testimonies that the workers have had to pick up a larger share of the premium for health care. And over this 4-year period, the employee contribution towards the total premiums has increased 200 percent. That would be double the increase that the employers had to pay.

Now, is the increase in premium attributable due to the increase in health care costs, or to the specific types of health plans and services that these locals have negotiated?

Mr. SWEENEY. We think that it is due to the increased cost.

Senator HATCH. All right. I appreciate your testimony and appreciate having you here.

Mr. SWEENEY. Thank you.

Senator RIEGLE. Let me just say also, for the record, that in our HealthAmerica plan we do not specify a percentage rate. I know, Senator Hatch, you have used the 7-percent figure. That is something that would have to be negotiated and worked out.

And it is up to the Secretary of Health and Human Services to finally establish that percentage. But we do not set forth a specific percentage in our bill.

Senator HATCH. I understand that. But 7 percent has been mentioned as a possible percentage. And my point is, is that if costs are going up 12 percent, it seems unlikely that 7 percent is going to cover these costs. In fact, it is impossible for them to.

And if they do not cover these costs, then that means they are going to be asking us to put more and more money in, at least up to 12 percent. And if Mr. Sweeney is right, it is going to go from 12 to 23 percent. That means it will be a never-ending source of taxation to the American workers in this country if we go with a play-or-pay system.

In other words, it will never end and we will have the almighty Federal Government, I think the worst to handle these type of situations, doing the handling in what would really amount to a Federal Health Welfare system where, as you have indicated, a lot of businesses are going to have to move into that system rather than continue to try and provide private health insurance coverage.

So, what it means is that ultimately we will have a Federal Health Welfare system that will be basically socialized medicine run by the Federal Government with the costs ever-escalating.

And, I might add, not applicable to us wonderful members of Congress. Of course, we exempt ourselves from this approach, if we use the play-or-pay approach. And those are just some of the reasons why I am having lots of problems with the so-called play-or-pay approach, or I call it the Mitchell-Kennedy mandate, or you can call it the——

Senator Durenberger. And Riegle mandate.

Senator HATCH. Well, and Riegle mandate. I have got to give you credit for it.

Mr. SWEENEY. You can call it anything you want, Senator. But the fact of the matter is, we need national health care reform.

Senator HATCH. Well, now, I agree that we need to do something about our system. And I think it needs to be done on a very intelligent basis. What I am suggesting is pay-or-play is not a very intelligent basis. In other words——

Mr. SWEENEY. But if it does not address the cost issue in a strong way——

Senator HATCH. No, I agree.

Mr. SWEENEY. You are just wasting your time.

Senator HATCH. No health care system that we can come up with can fail to address the cost situation. We have got to do that. But the question is, how do you do it?

Do you do it through mandates from the Federal Government, or do you do it through incentives that might bring the costs down, or in a variety of other ways that are reasonable cost containment approaches? I know you just want to solve the problem.

Mr. SWEENEY. All I know is that voluntary ways do not work.

Senator HATCH. Well, I am not suggesting voluntary ways. I am suggesting that there are effective ways that we can bring costs down through effective cost containment through Medicaid reform, Medicare reform, medical liability reform, antitrust reform, insurance reform, and, really the most important reform of all: regulatory reform, which, of course, would help to bring down the paper work and the excessive costs that are eating you alive, your employee members alive, and businesses throughout this country alive.

And to turn to a system that is likely to indirectly get us into a socialized medicine run by the Federal Government, it seems to me, is not the way to go. But I am going to keep listening, and we are studying this as hard as we can.

And I agree that we have a role here that has to involve resolving these problems, or by the year 2020 we are going to be spending 32 percent of our Gross Domestic Product on nothing but health care, and there will not be any monies left to do very much good for all of the other social needs of our society.

So, you are raising a very important issue. We want to solve this problem. We are going to solve this problem one way or the other. I just do not think play-or-pay is the way to do it.

Senator RIEGLE. Well, with all due respect, because some things were said that I think were not accurate, just for the record, as an

author of the plan that has been mis-described here, I want to just say a word or two about it.

Our bill, S. 1227, that has been put together by Senators Mitchell, Kennedy, Rockefeller, and myself, I think is a good proposal. And, of course, I welcome any competing proposal.

I mean, we will put ours right here. And I am quite happy to take one that Senator Hatch or anybody else wants to put right here and we will take a look at it. And if they can find ways——

Senator HATCH. It will be there.

Senator RIEGLE. Well, I know. But until it is, it is not. And, with all due respect, these are very difficult issues that buzz words do not answer. In other words, we can talk about reform until we run out of breath to say the word. But we have got to actually put a formulation on the table.

Let me just say, Senator Hatch, I know how strongly you feel about these issues and the fact about seeing that people get good health care.

Senator HATCH. I do.

Senator RIEGLE. I do not assert, by the way, that this is a perfect package by any means.

Senator HATCH. No.

Senator RIEGLE. But I will tell you this, it is far preferable to what we have now and it is far preferable to no package. In other words, it is not enough to talk about what we need and not put something on the table for discussion.

Now, when Mr. Sweeney indicates—and you tell me if my memory is right on this—I think he said that within roughly a decade's period of time with the cost increases we are seeing right now, it is going to cost a family about $20,000 a year to provide basic health insurance coverage for themselves.

Now, that is just out of the question. I mean, most of the families in the country do not earn $20,000 a year, so they are not going to be able to pay that much for health insurance coverage. Did you not indicate that? What does your data show?

Mr. SWEENEY. That the cost of health care to employers and individuals who are paying their own health care would rise to approximately $20,000.

Senator RIEGLE. Yes. Over what, roughly a 10-year timeframe?

Mr. SWEENEY. That is correct.

Senator RIEGLE. You see, that is the thing that is bankrupting us right now. You know, the other day the Chamber of Commerce was in and they were followed by the independent business people. The thing that is now at the top of their list is health care reform.

I mean, that is what the business community is here to talk about. We are about to hear from some of the large business witnesses here today to talk about what this involves for them.

But what I am hearing from the realtors that were in the other day, the business community is tearing the door off the hinges, coming in to say, you have got to do something about controlling health care costs.

You have got to do it, because it is not just crippling families and individuals, it is killing businesses. It is making us uncompetitive in world markets. We cannot just keep talking about it, we have

got to have proposals. If somebody can give me a better proposal than this, then I am interested in the better proposal.

But, if the alternative is just more studies, more talk, more delay, more cost increases, we are going to get around to it some other time, we will have a proposal for you later—I went to see the President 1 day on this very issue. I said, let us work something out.

And he said, well, go and talk with Mr. Sullivan. I went to talk with Mr. Sullivan over in the Cabinet Department to see if we could not work something out. We are still waiting. We are still waiting. And I would like to work something out on this. I am not wed to this in every specific detail.

Senator HATCH. Would the Senator yield on that? I really appreciate the distinguished Senator and his efforts. We have worked together in the past. We have met together regularly. I happen to disagree on this proposal. And it is not a simple thing to put together.

The President's plan is coming up in segments as they legislatively draft it. And legislatively drafting a comprehensive health care plan to resolve our problems is a very, very big thing to do.

And we are finding that in my case, because we are drafting our bill and we are hopeful that we can have that here within the next month.

So, there are a lot of good people working on this, not the least of whom is the distinguished Senator from Michigan. And he is a friend, and I appreciate the work that he has done in the health care area.

All I am saying is that I am finding fault with the play-or-pay plan. From that standpoint, I want to give the Democrats credit for putting that on the table.

Finding fault with it does not mean that I am disparaging the efforts that have been put forth. What I am trying to do is to get us to the point where we can come up with that compromise or that approach that is really going to get these costs under control.

Now, one of the major problems with the play-or-pay method is that you are going to have price restraint or price controls. Now, the distinguished Senator may disagree with me on that, but that is not the way to get matters under control. There are better ways, and I think we can do it.

And if I do not miss my bet, I will bet you money that the distinguished Senator from Michigan, and myself, and a number of other Democrats and a number of other Republicans are going to get together on this.

It probably will not happen in this election year, because it is too much of an election year. But it is certainly going to happen next year, and certainly no later than that.

Because you are right, Mr. Sweeney. I have a lot of respect for you. I have watched you through the years. You are absolutely right. We have got to get these costs under control.

The distinguished Chairman is right. We cannot just ignore this problem. We have a role in the Federal Government, since we are paying a pretty whopping cost of the cost of health care.

And there are ways of doing it that can be incentivized by the greatest free enterprise system in the world, not by the greatest so-

cialistic system in the world, which has just fallen. And I think what we want to do is just continue to work together, and I appreciate my friend offering to do so.

I offer back to work with him every step of the way and to try and find a way to bring everybody together to resolve these problems in the best interests of all workers in America, all employers in America, and really the American taxpayers.

And I think these types of hearings are critical. I also think that this type of debate is critical, and I think your testimony has been critical here today.

So, I appreciate you being here and I just pledge to you that I will be one of those who will be working as hard as I can to resolve these difficulties and do it in a way that benefits our country as a whole.

Mr. SWEENEY. Thank you.

Senator RIEGLE. Thank you very much, Mr. Sweeney. It has been very helpful.

Mr. SWEENEY. Thank you, sir.

Senator RIEGLE. Let me now call our next panel which consists of national experts, who can give us information about employers' health care costs and the impact that we have been looking at here this morning on businesses, workers, and on consumers.

So, let me invite up now Mr. Moran, Dr. Brailer, and Mr. Maher, and let me introduce each as they are coming up.

Mr. Donald Moran is senior vice president of a company called Lewin/ICF, which is an independent health care research consulting firm. He is an author of "Employer Cost Shifting Expenditures," which is a report prepared for the National Association of Manufacturers.

He will be presenting us with information quantifying the cost shifting problem that employers face, and its distribution among different industries and by the size of the various companies.

Then we will hear from Mr. David Brailer, who is the director of the Health Care Reform for American Competitiveness Project at the Wharton School of Business. He has obviously been deeply involved in this, and will discuss the results of the research that he has been conducting with his colleagues on this issue.

And then we will hear from Walter Maher, who is the director of Federal relations at the Chrysler Corp., who will discuss how high health care costs affect businesses, and, very particularly, how it is affecting the automobile business in today's international global economy.

Mr. Moran, we will start with you. And all of you, we will make your full statements a part of the record. We would like you to summarize and feel free to make references to any of the discussion that has gone before this morning. Mr. Moran, let us hear from you, first.

STATEMENT OF DONALD W. MORAN, SENIOR VICE PRESIDENT, LEWIN-ICF, WASHINGTON, DC

Mr. MORAN. Thank you, Mr. Chairman. I am Don Moran, with Lewin-ICF, a Washington-based health policy research and consulting firm. I am here this morning to briefly summarize for you some

of the key findings of a study we conducted on behalf of the National Association of Manufacturers.

Let me say at the outset that I do not appear this morning as a representative of that organization in any sense, but I am here to present the findings of that research in a way that I hope you will find helpful as you consider these matters.

The subject matter, as you have suggested for my remarks this morning, is the phenomenon of cost shifting, whereby costs in the health care system are passed back and forth between different parties. I am going to offer you briefly two views of that issue this morning.

First, I am going to touch briefly on the traditional view of cost shifting which suggests that certain types of insurance payers, because of their relative power in the marketplace, are better able to dictate prices in the system in a way that permits them to pay less, inducing others to pay more of the cost of running the overall health care system.

For reasons of measurement, I want to concentrate my observations about that this morning on the hospital industry, although there is some evidence that cost shifting is a broader phenomenon than simply what takes place in a hospital.

The traditional contention about cost shifting is that recent changes, particularly in reimbursement policy at the Federal level over the last 10–15 years, have resulted in a reduction of public program support for the cost of running hospitals, with the result that hospitals are facing shortfalls in their gross revenues relative to costs raised the charges that are ultimately paid by all other private payers.

The evidence that we are able to ascertain from our work for the NAM is that that is, in fact, happening; that the numbers are large and material. And I would like to briefly summarize this from the hospital perspective, if I may.

In my written testimony I have two tables. The first table presents the overall issue from the hospital perspective and presents data on estimates for 1991.

We estimate that the total amount of uncompensated or undercompensated care—which is to say costs not covered under insurance at all—totalled $10.8 billion in 1991, which is roughly equivalent to the amount by which the payment of less than full accounting costs by public payers totalled up to about a $21.5 billion cost shift in the system from those sources.

As you will see in the table, the uncompensated cost and the payer difference cost shift are roughly equal of magnitude, at $10.8 and $10.7 billion, respectively.

I think you will also see that the estimates we present square with most analysts' perceptions of the issue, that the single largest contributor to the payer cost shift is Medicaid programs throughout the United States which traditionally have paid substantially less than even average costs to most hospitals.

Medicare is a small and significant number of $2.2 billion, though I must say, that in comparison to where Medicare was 6 or 7 years ago when it was paying substantial positive margins, the trend over time has produced substantially greater cost pressure

from Medicare reductions. And CHAMPUS, we estimate, contributes a minor amount to that.

Senator RIEGLE. Now, let me just stop you right there.

Mr. MORAN. Certainly.

Senator RIEGLE. Because I want to make sure that this is just clear as a bell as to what you have found here.

As I read the chart that you just made reference to, you are saying that hospitals across America, when they provide care to whoever walks in the door, that some of the care they are providing they do not get paid for by the person that they are giving the care to.

I mean, if it is a welfare person and they perform $100 worth of service, maybe they are only getting paid $50 to cover that. Is that correct?

Mr. MORAN. Yes. They are being paid something less than a dollar for every dollar, and, in many cases, zero.

Senator RIEGLE. Yes. They are being paid less than what they actually spend to treat that person. And that cost has to go somewhere.

And what is happening is, according to your studies, that cost then gets shifted over and gets put into the charges that are made against patients who come in who have normal health insurance coverage.

Mr. MORAN. That is correct, Mr. Chairman.

Senator RIEGLE. It might be a health insurance plan they have from their business, they might have their own health insurance through Blue Cross, or what have you.

But that hospital patient who has some kind of private insurance ends up, in effect, paying more than they otherwise would pay because these costs are getting shifted from one patient over to the other patient.

And, because of that, that is one of the things that is driving up the cost of health insurance for the people who are covered by health insurance. Is that what is going on here?

Mr. MORAN. That is the effect.

Senator RIEGLE. And you are saying that last year, 1991, just in terms of hospital costs alone, that nearly $22 billion worth of cost were shifted over and had to land on the people with insurance, obviously driving up the cost of that insurance. Is that what your finding is here?

Mr. MORAN. That is correct. The costs have to go somewhere, and if they are not being recovered from either uninsured patients or patients whose insurance pays less than cost, the hospitals have to raise it some way, and the most common method is raising charges to people with private insurance.

Senator RIEGLE. Yes. Now, just to finish, and then I want you to continue.

Mr. MORAN. Certainly.

Senator RIEGLE. But I want this to be understood, because it is a very important finding. If we could find a way to stop that cost shifting, in other words, the people who came in and got that nearly $22 billion worth of coverage, if that coverage was, in fact, paid for in some fashion directly to those patients, then that $22 billion

would not come on over and land on the private insurance system and drive those rates up by $22 billion. Is that correct?

Mr. MORAN. That is correct. I mean, if you adopt a policy that brings in resources from elsewhere, then it is no longer necessary for the private insurance market to carry that load.

Senator RIEGLE. All right. Why do you not continue?

Mr. MORAN. One point I wanted to make about this that distinguishes, perhaps, the difference between this traditional view of cost shifting and another one I am going to share with you in a moment, is that, as we said a moment ago, some part of that $22 billion is health care system costs that is on behalf of people who have no insurance whatsoever.

It is important to note, however, that that is not the same thing as to say that those people are unemployed. In fact, a significant number of the uninsured in America are employed.

Senator RIEGLE. Most of them are.

Mr. MORAN. That is correct.

Senator RIEGLE. Most of the uninsured actually work. I mean, they are employed, but they just do not earn enough. They do not get any health care coverage, they cannot afford to buy it, so they do not have any health insurance coverage.

Mr. MORAN. That is correct. But the thrust of that, Mr. Chairman, is that in one sense, that portion of this cost shift is not so much a cost shift between hospitals or private payers and public payers, but sort of a cost shift back and forth among employers of different classes, depending on their willingness to provide insurance or their ability to provide insurance.

In the next few minutes, I would like to briefly summarize this inter-employer cost shifting phenomenon. Because we estimate that for many businesses that may be a far more significant cost shifting issue than simply cost shifting back and forth between public and private payers.

The story unfolds because of the reality of the growth of two-income households in the United States, a significant number of American families have both parents in the household working.

The common problem that they usually face is that in many cases they may be offered some form of health insurance by both employers, one or the other.

And, naturally, as you would expect in this world, families will often find themselves having to face the choice of which health insurance package they accept, and balancing out the scope of the coverage provided, the out-of-pocket costs in the form of premiums and other cost sharing. And most people, I think it is fair to say, make rational decisions.

The interesting thing about that, though, Mr. Chairman, from the perspective of what we are talking about today, is that, depending on which employer's insurance coverage gets selected, in effect, a worker, in this case, a spouse of a person who elects coverage under the package, will become a dependent on that employer's insurance policy, even though that dependent may, in fact, be the employee of somebody else.

So, what we have tried to do in this work for the National Association of Manufacturers is to investigate the scope of that. And we

found that it is, in fact, a very extensive phenomenon in the United States.

In fact, over 17 million American workers are enrolled as dependents in coverage provided by someone other than their own employer.

So, in fact, it is a very significant proportion of the work force—probably 15 percent of the work force—that is, in fact, receiving their employer-based health insurance from someone other than their employer.

The cost of providing that coverage in 1991, we estimate, is about $26 billion, which amounts to about 20 percent of all the costs of entire employer health insurance systems.

So, in effect, the 20 percent of the cost of employer-based health insurance is for providing coverage to people who are working somewhere else than the employer that is providing it.

In my prepared testimony, I present a second table from the National Association of Manufacturers study. And I think if you and your colleagues would take a moment to examine that, you would discover that there are a number of interesting lessons to be learned.

I will not belabor all of the detail in this table because I think much of it is self-evident. But I take four major conclusions from our work in analyzing these inter-employer cost shifts that may be material for your deliberations on these matters.

First, there is a very significant difference in this inter-employer cost shift between small employers and large employers. In fact, as the table suggests, even when you factor in the cost share of the payer differentials from Medicare and Medicaid, very small firms are significant beneficiaries, in effect, of this inter-employer cost shift. In fact, the magnitude is eight times greater than the costs that they are bearing in the form of cost shifting from Medicare, Medicaid, and uncompensated care.

Secondly, the largest employers are, in effect, carrying the entire freight in this system with respect to working dependents, and that is not surprising because if you expect households to make rational decisions, then they will go where the coverage is best.

And the coverage is typically best in large, organized work forces, and that is where people ultimately wind up in the system when they have a choice.

And the third point I would make is that, as you can see from the detail provided at the bottom, this is not a random distribution of costs by industry. And, in fact, there is a significant inter-employer shifting cost among sectors in our economy.

In fact, of the entire net $17.2 billion in cost shifting, which we think the employer sector experienced in 1991, 88 percent of that, net of all other factors, fell on the manufacturing and transportation industries in the United States, for the reason that, historically, they tended to have substantially better benefit packages.

I guess I would also note in passing that the Federal Government, as an employer, along with State and local governments, is also a significant net payer in this view of cost shifting because governments employ a significant number of people and pick up dependents in various aspects of the system.

So, in all, I think it is fair to say that the traditional view of cost shifting is only part of the story. And, in understanding where employers are coming from and wrestling with these questions, it is important to understand that there are cross subsidies back and forth across the spectrum of this system and that, in reality, the problems of employer-based health insurance may be, while pervasive for all, particularly acute in those sectors that are picking up the cost of covering dependents as well as providing coverage for their own workers.

Senator RIEGLE. Thank you. Let me just say on that point, I think you have really hit on something that is really valuable here. And that is, because, as you point out, the work patterns have changed in American families.

Now, in most families, both husband and wife are working and out in the work place. And they may both have some measure of health insurance coverage, but they are going to opt for the better coverage, whichever one happens to have that through their work place.

And, in light of that, and in looking at the fact that, in the manufacturing industry particularly, but others that you cite, that there has been this pattern of better health care plans over time, that that would cause families to gravitate toward that coverage if either the man or the woman is working in a manufacturing industry to take that coverage.

And then that has the effect of creating, as you say, kind of a cost subsidy from the large firm, really, down to the smaller firm.

But, as we watch the number of manufacturing jobs disappearing in America, and that total is dropping sharply; that is one of the reasons why the middle class is shrinking because these jobs that generally have had higher value-added and higher pay and standard of living associated with them are becoming fewer and fewer in number.

It would be very interesting to try to do an analysis, say, if we went over the last 10 years. And if the manufacturing sector where the middle class jobs have been, if it were relieved of rising health care costs—which is the case in other countries that have national health plans of one kind or another—if our manufacturing firms were not carrying this enormous weight of these rising health care costs and if they had not been carrying it over the last few years, the question in my mind is, how many manufacturing jobs would there be in America today versus what we are actually finding?

And I believe, based on the scale of these numbers, that now we are down to this number, say, of manufacturing jobs in America.

And if we had not been carrying this huge burden of health care costs so inefficiently over the last several years, I think the manufacturing job base would be much larger and we would have many more people working in that sector, earning higher wages than they probably are now earning. They would be better off, and the country would be better off. In other words, we would be seeing lower unemployment, we would be seeing higher incomes, we would be seeing people with higher incomes paying more taxes into the government, which means our Federal Government deficit would come down.

In other words, I think there is probably some number of manufacturing jobs in America over the last 10 years that have disappeared under the weight of these health care costs that are excessive and just cannot be borne by our manufacturers; not in this new international economy when we are trying to sell an American-built car or truck versus a Japanese-built car or truck.

If we load on these very high health insurance costs on the ones we build here, and they have a very low cost on the ones they build in their country, it is not surprising that that is part of the problem as to why they have been able to surge and we are struggling, to a greater extent.

Would it be possible for you, based on the data that you have, without great effort, to try to give some estimate, going back sort of like a regression analysis, to see how many manufacturing jobs we may, in fact, have lost on the margin, going back, say, over a decade?

Because we may have found here today one of the reasons why unemployment is so high, we are seeing all of these plant closings, we are seeing this loss of manufacturing jobs.

A significant part of it, I think, maybe traceable right back to this crazy way in which we mis-finance our health care system. I mean, does the logic hold together for you? Could you put something together like that for us?

[The following information was subsequently received for the record:]

NATIONAL ASSOCIATION OF MANUFACTURERS,
Washington, DC, June 5, 1992.

Hon. DONALD W. RIEGLE, JR., *Chairman,*
Subcommittee on Health for Families and the Uninsured,
Senate Finance Committee,
U.S. Senate,
Washington, DC.

Dear Senator Riegle: The May 18 hearing held by the Subcommittee on Health for Families and the Uninsured/Senate Finance Committee on the subject of health care costs and competitiveness included two witnesses who testified on the results of two NAM-supported studies: "Employer Cost-Shifting Expenditures" conducted by Lewin-ICF and "The Impact of Health Care Spending on U.S. Firms" conducted by The Wharton School/University of Pennsylvania. We are pleased that these NAM efforts have been useful in providing information to the Subcommittee in its quest to develop a workable health reform plan.

Your question to Don Moran of Lewin-ICF regarding identifying the number of jobs lost as a result of health care costs is also of great concern to NAM. Frequently, our members call us to discuss the problem of rising costs and what this means in terms of fewer dollars available for training, purchase of new equipment and other essential investment needs. Other than this anecdotal information, we are not aware any hard data exist to substantiate this problem. NAM is currently conducting a survey of its members on costs and health care reform, results of which we will share with you later this summer.

Lewin/ICF has indicated that it may not be possible to directly address your question due to lack of information. While longitudinal data exist on employment by corporate performance, longitudinal data on health care costs by employment sector are rather limited. Even with sufficient data, linking the two would not necessarily give good results, according to Lewin/ICF's Don Moran, since health benefit costs are just one economic variable among many other factors of production.

The research conducted by Wharton did not provide clear evidence linking loss of jobs to health care costs. To quote David Brailer's testimony, "The net effect of industry's response to high health benefit costs is that the American public pays higher prices for some goods and services, receives lower wages in many labor markets, and receives lesser quality and eroding health benefits from some employers." Phase II of this research (not funded by NAM), as we understand it, will examine the ef-

fect of health care costs on firm production costs and overall firm-performance. Site visits will be conducted to companies in selected industries. We anxiously await the results of this study, particularly as it bears on the relationship to job loss and overall corporate competitiveness.

In the meantime, NAM will continue to work with the Subcommittee, the full Finance Committee and the other committees in the Congress to enact health reform legislation which controls costs and expands access to the uninsured. Since consensus on broad reform appears elusive at present, we support certain market reforms that appear to have a broad base of support. To this end, we support the Bentsen bill (S. 1872) as a good first step toward future comprehensive reform.

Sincerely,

MICHAEL E. BARODY, *Senior Vice President, Policy and Communications.*

Mr. MORAN. I think, certainly, the logic holds together from the economic standpoint. It is pretty clear that when you differentially load costs onto a particular sector of that economy, that is equivalent to an excise tax on the operations of those industries, which raises the cost of the ultimate product that they deliver to the end consumer, both domestic and foreign, and it results in a lower level of demand for their products than would be the case otherwise.

I will respond to the letter of your question and indicate to you that, given the character of the research we did, it would not be easy or automatic to translate that into a specific estimate of the magnitude of the effect, though, from the standpoint of the logic of it, it is inarguable.

Senator RIEGLE. I understand.

Mr. MORAN. But, I will say, in order to put my comments in some degree of balance that there are qualitative differences between the U.S. health care system and the health care systems prevailing in other industrialized countries. It is possible to take different views as to whether that is a good thing or a bad thing.

Senator RIEGLE. Right.

Mr. MORAN. But whatever that thing is in terms of the scope of coverage, the nature of the technology employed, the degree of amenities and the form of freedom of choice, and other things that are in the system, do provide something to Americans who have access to the system that is different than what workers receive in other countries.

But I think, notwithstanding that, it is pretty clear that the effect that you are hypothesizing is a logical one and I am sorry that we cannot elucidate that more clearly for you this morning.

Senator RIEGLE. Well, but let me just finish with this, and then I want to go to our next two witnesses.

Now, you did this research that you are summarizing today for the National Association of Manufacturers. And it would seem to me to be strongly in their interest that if what we just said is true, that the manufacturing base is shrinking in America in part because of this enormous health care cost burden that manufacturing is carrying to a much higher percentage than others, in order to marshal the public consensus and will to change this, if it can be shown that we have many fewer jobs in the manufacturing sector; middle-class jobs, good jobs, jobs that pay pension benefits at the end and provide a decent standard of living; if we can identify that the manufacturing base is smaller and is shrinking faster than otherwise would be, it would be profoundly in the interest of the Na-

tional Association of Manufacturers itself to be able to make that statement.

It would be useful to take this data and to sort it out and to be able, perhaps, to say if we had done something 10 years ago to get the extra burden off of the manufacturing sector, that we would probably have another 2.5 million or 5 million manufacturing jobs in this country today, with perhaps an average annual income of, say, $30,000, or some figure that would be quite attractive for many people today who are looking for jobs and cannot find them. That is a very compelling argument for not postponing any longer this debate on health care reform.

I mean, if we are losing jobs, as I submit we are, particularly high value-added manufacturing jobs, because we have got a health care system that is out of control and we are not fixing, that is of acute interest to the country.

We just had a situation the other day where they opened a retail outlet over in western Michigan. It was either a K-Mart or a Wal-Mart. They were offering maybe 150 jobs, and something like 4,000 people showed up for those jobs.

Now, those jobs would pay far below the normal manufacturing wage. But people are desperate for work in the country. It is all over the country. It is pervasive.

So, to the extent that we are undermining our own economic future here, especially by killing off the very kinds of jobs we need more of, this is a very compelling argument to lay on the table. And it seems to me you have presented that today.

You have, in effect, have reached through all of these numbers and you have identified this extra burden that is weighing down on the manufacturing sector. And I think our other witnesses are going to reinforce this point.

We are seeing total employment in that area dropping. Here is a chance for us, by solving one problem, to solve another problem. If we solve the health care problem, we are going to have more manufacturing jobs and we are going to have fewer unemployed people and we are going to have a stronger country.

If you can help us making that identification, I think it also creates some greater urgency to get on with this task because there is a lot of jawing around the Congress about more jobs. Here is a way to get more jobs.

Let us move ahead. I am going to ask you to talk to the Manufacturer's Association and see if they might have some interest in doing this and see what you can pull out of your data that could help make this point for us.

Mr. MORAN. I will do that, Mr. Chairman. Thank you.

Senator RIEGLE. Very good.

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

Senator RIEGLE. Dr. Brailer, we are pleased to have you. We will make your full statement a part of the record. We would like to hear your comments now.

STATEMENT OF DAVID J. BRAILER, M.D., INSTRUCTOR, HEALTH SYSTEMS DEPARTMENT, AND DIRECTOR OF THE HEALTH CARE REFORM FOR AMERICAN COMPETITIVENESS PROJECT, WHARTON SCHOOL OF BUSINESS, ATTENDING PHYSICIAN, THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA

Dr. BRAILER. Thank you. I am David Brailer, and as was said, I teach management and economics and do research in that area at the Wharton School of Business in Philadelphia.

I am also a practicing physician at the Hospital of the University of Pennsylvania. My testimony today is that of an analyst and not necessarily that of a physician.

Over the past 3 years, myself and other researchers at the Wharton School have studied health care spending and the competitiveness of the United States' industrial base in the world market, and in our own market.

We have performed this work with the advice and support from business, the John Huntsman Center for Global Competition at the Wharton School, the National Association of Manufacturers, and several other organizations.

Our principal goal is to help industry leaders and policy makers such as yourselves define the role that business should play in the future of health care in delivering health care to employees, and we include in that internal health cost management within the firm, and, of course, external public policies, as we are debating today.

Our research and my testimony today is not intended to advocate a specific policy for reform or a specific ideology to drive that, but to try to set a framework in which we can better understand health care spending and competitiveness.

The central result of our work is that health care costs may have an impact on our economic competitiveness. The current effect would arise, however, not from declining market shares or slowed global expansion across the industrial base of the United States, but, more importantly, from a threatened standard of living of U.S. citizens.

In the future business performance may decline as well, and we are concerned about that. Health care reform is certainly important for this reason, but for many others, as you know.

Business leaders' view of firms' competitiveness in terms of its market share or its corporate performance, and this drives concerns about the magnitude of health benefit costs relative to operating costs, output, or profits. Economic competitiveness, though, which is what we are concerned about, would not consider just the current practice of a firm and its current performance in the world market, but also its long-term ability to compete and also the standard of living at home. We believe that economic competition captures the balance that is essential between firm performance and citizen growth that is necessary for both.

We found that industries, indeed, respond differently to rising health care costs. Firms in autarkic industries, ones in which competition from a world base cannot occur—service operations, hotel and travel services, financial companies, even public sector agencies—probably pass on health care costs in their prices. Because there is no low cost competitor in these markets, the American

consumer does pay for these costs through the prices of goods and services, some of which we would deem essential.

Firms in previously globalized industries—this is heavy manufacturing, electronics, and chemicals, industries in which globalized occurred many years before and is somewhat stable at this point—offset health benefit costs with decreases or slower growth in money wages and do not exhibit large price increases, at least driven by health benefit costs. The labor market, in this case, adjusts for those costs.

Of course, as we have heard many times, some small firms, retailers, and seasonal firms, reduce the level of health benefits and other benefits offered employees without adjusting wages.

Importantly, the result of these actions is that most industries have been able to pass their health costs back to the public in some form, and to keep themselves efficient within their markets.

In doing so, however, this may place the standard of living of the United States at risk. The public pays higher prices, gets lower wages, and has lesser quality benefits. If they don't value health care more than this cost, then their standard of living may be declining.

The corollary of this finding is that there does appear to be any evidence that health benefit costs are a significant factor in overall industrial prices or in the share of domestic or global trade held by U.S. firms.

The current financing of health benefits, in fact, may aid some industries. There are some winners and losers. Particularly here, I note two industries.

First, those that sell health care products or technology. Many of these industries are net exporters, having posted a $3 billion trade surplus in 1990. They bring benefits to the economy beyond the trade surplus. For example, they may create technology that can support innovation, inefficiency improvements, and other productive industries which are trying to compete in world markets.

On the other hand, it follows that if some industries derive benefits from the current health care system, others may be harmed by it. Indeed, some industries, such as automobile manufacturing, are facing a late and rapid transition into globalized markets.

In these industries, health benefit costs are, high. But this cost is only one of many high costs that they face. The health care reform debate, then, does not give justice to the multiple dimensions of competitiveness in these industries.

We question if health care reform will, in itself, improve their competitive performance.

Beyond our concern about current costs, our research suggests that the current practice of health benefit management could place the core confidence of many U.S. firms in jeopardy in the future. This is the long-term competitiveness issue.

For example, as we have heard, although many issues underlie strained labor/management relations, a dispute over the cost of health benefits can harm a firm's competitive performance by diminishing its stability, technical growth, or quality management. These are all principal attributes of world-class competition.

Likewise, when firms offer health benefit packages with faulty assumptions about the underlying and high rate of health plan cost

growth, downstream costs that exceeds those that are projected have to be funded from other sources, such as that allocated, as we found, in soft budgets; things like employee training, or research and development.

These, again, are principal attributes of firms trying to compete in world markets. These examples show how seemingly correct business decisions can harm the skills, innovation, or growth that are key attributes of world-class firms, and demonstrate why businesses must commit themselves to be active, meaningful buyers of health care services in the future and why a health care system reform which promotes these principals should occur.

At present, the effect of health care spending on the American standard of living appears to be of greater concern to us than its threat to business performance. For the future, the key issue is not that health care costs prevent businesses from winning head-to-head price competition in world markets, but that increasing health care costs in the current manner in which they are managed, makes it difficult for firms to train workers, invest in innovations, cooperate with labor, and do the things that are necessary to compete in world markets.

The standard of living of our citizens and the performance of U.S. businesses may be slowed in the future without significant reform.

Senator RIEGLE. Thank you very much. I want to come back and get into some of those issues, but I want to hear from our next witness before I do. But, let me understand. You, in fact, are also a physician yourself, are you not?

Dr. BRAILER. That is right.

Senator RIEGLE. And can you tell me just what your area of medical specialty is?

Dr. BRAILER. I practice General Internal Medicine with an inner city practice in West Philadelphia.

Senator RIEGLE. Very good.

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

Senator RIEGLE. Mr. Maher, we are pleased to have you. We have had occasion to hear you in other settings, and especially welcome you today.

STATEMENT OF WALTER B. MAHER, DIRECTOR, FEDERAL RELATIONS, CHRYSLER CORP., WASHINGTON, DC

Mr. MAHER. Thank you, Mr. Chairman. I am pleased to be here today. I would like to discuss with the committee why we agree with what we have just heard from Dr. Brailer regarding the harmful impact that health care costs have on the economy.

But, in addition, we would like to discuss with you how the absence of any health policy in the country, how the absence of any process to control costs, and the reliance, instead, on cost shifting has harmed the manufacturing sector of the economy, and, particularly, mature firms, as we have heard from Don Moran.

A key starting point, Mr. Chairman, is that the major reason health care cost is threatening this country and the major reason that they are increasing is that we simply do not have a process to budget health care costs or otherwise control it.

Instead, the major players have found that, in the absence of a policy, it is an awful lot easier to shift costs, or, frankly, to avoid them altogether, than it is to put the discipline in the system to control costs, despite the fact that they realize that this is doing nothing to control aggregate spending.

Frankly, health care cost is no less of a problem to the economy simply because the public sector, for example, has found a way of covering only 4 out of 10 poor, or, for Medicaid paying maybe 60 cents on the dollar, shifting costs to the business community, and then maybe taking pride that, well, our tax burden is lower because of that.

In the same way, the business community, in its ability to shift costs to employees or to raise prices to consumers, health care cost is no less of a problem to the economy because the business community has the availability to shift those costs, creating what, indeed, is a short-term operating cost reduction.

And I emphasize short-term, because I agree with Dr. Brailer, that pursuing this short-term shift-cost mentality, in the long run, destroys the standard of living of citizens.

But, unfortunately, it has been successful for many in the business community and it keeps them on the sidelines in terms of this health care cost debate.

Why does it not make sense for the economy for all this cost shifting? The reason is that citizens, who are the ultimate shiftee, do not have anyone to shift costs to. They end up with less disposable income.

Senator RIEGLE. In other words, they sort of get shifted, or maybe shafted is the right word, at the end of the process.

Mr. MAHER. Right. I have heard our system referred to as a system of shift and shaft. But, in any event, citizens end up with less disposable income, a lower standard of living. It creates a stagnating economy.

People, for example, Mr. Chairman, wonder why, with the slight uptick in the economy, the slight growth in GNP, why is the economy still lackluster? Why are consumers not really vigorous?

Well, when you go behind the numbers you see that a significant share of the meager increase in our GNP is simply new health care consumption. Health care costs do not make for a robust economy, and that is bad for all business.

A further problem, Mr. Chairman, is that after the dust settles with all of the cost shifting, we find that not only is our economy, per se, overly burdened by health care costs, but that those costs are distributed most unfairly through the economy.

And it has been particularly harmful—and I think Don Moran's testimony bore this out—to the manufacturing sector, and particularly to mature firms. Let us examine why.

All of the poor not covered by Medicaid, all of the employed uninsured are not immunized from illness. They still get sick, they go to the hospital, they get treated when they get very ill. How do the bills get paid?

Well, the phenomenon of cost shifting is, indeed, an indirect tax, and private sector bill payers have their bills padded. Who is the largest component of the private sector bill payers? Business.

Question: all business? No, just businesses that offer health insurance. So, it is a self-selecting process. If you want to avoid the cost shift, there is one easy way: stop being a health care bill payer; do not offer insurance.

That does not do much for the access problem in this country, but it does help that particular business to dodge the bullet.

Now, some can avoid this easier than others. Some firms find—and my company has been among those—that where you implement though cost containment strategies you have strained personnel relations, maybe you have some union unrest. We heard Mr. Sweeney this morning testifying about the incidents of strikes.

But the fact of life is that many, many businesses, and particularly many small businesses, have got the message. They have the ability to dodge this bullet and they are frankly lobbying like crazy to keep the ability to dodge the bullet.

The great growth in this economy has been in retail and service jobs concurrent with the growth of two-income families. Guess who is more likely not to be offering coverage? It is the small retail or service firm.

Guess who is getting stuck with the costs? The larger business, typical of which are manufacturers, typically employing the major wage earner of the family, and obviously getting stuck with two health care bills.

Frankly, also, guess who is most likely to be involved in foreign competition? It is the manufacturing firm, not the small retail firm.

Now, how significant is this tax? The study that Mr. Moran's firm did showed that for the manufacturing sector, 28 percent of manufacturing's health care costs are accounted for by costs shifted from others.

And it is growing daily as small businesses drop coverage, it is growing daily as Medicare and Medicaid continue their cost shifting, and frankly it is growing far faster than any other manufacturing input cost.

The University of Michigan recently conducted a study and they found that the health care cost of General Motors, Ford, and Chrysler are growing at a rate 245 percent faster than the growth of their other manufacturing input costs, far faster than their ability to cut other operating expenses.

Unfortunately, Mr. Chairman, as bad as that is, not all manufacturers are impacted the same. This cost shift that the manufacturing sector of the economy as a whole has endured in the study that Mr. Moran's firm did for NAM, showed that the manufacturing sector, in total, absorbed $11.5 billion in cost shifts.

But how was that tax levied? Was it levied on the basis of ability to pay? Was it levied on the basis of the size of your payroll? Was it levied on your sales revenue? No.

Because cost shifting works as an addition to your health bills, the tax is based on how old your workers are, how sick they are, how many children they have, how many retirees the firm has.

In short, it is extraordinarily punitive to mature U.S. firms and creates a most unfair competitive disadvantage which no foreign enterprise faces.

So, manufacturers in this country, Mr. Chairman, are trying their best to cope. They are trying to manage their benefit programs as wisely as possible.

There are limits to what they can raise their prices, particularly in a sector of the economy as brutally competitive as the automobile industry is; there are limits on their ability to depress wages. They obviously are resorting to hiring fewer people.

There is more and more incidences across the manufacturing spectrum of seeing jobs relocated offshore. There is less money available for investing in training, job development, product development.

They earn less money, they pay less taxes, they pay less dividends. In short, it is not good for the business, it is not good for workers, it is not good for the economy.

So, in summary, we really need to get a process in place to control health care costs and to allocate those costs fairly throughout the economy.

The current health care system, in a very real way, penalizes the manufacturing sector to the benefit of the retail service sector, and the problem is getting worse as cost shifting pyramids.

We, frankly, Mr. Chairman, have in this country a health policy which favors the retailers of potato chips over the manufacturers of computer chips.

And I ask you, Mr. Chairman, on which of those sectors are you prepared to stake your faith in the standard of living of citizens of this country? Thank you.

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

Senator RIEGLE. Well, I think that is a very powerful point that you make. Can you give me in rough numbers now what you calculate the health cost per vehicle premium to be at Chrysler, over and above foreign manufacturers that are producing vehicles comparable to the ones that Chrysler makes?

Mr. MAHER. Mr. Chairman, as I think you mentioned in your opening remarks, the University of Michigan just completed a study on this where they looked at data from General Motors, Ford, Chrysler, and parts manufacturers that we buy parts from.

They looked at this data across the United States and Canada, so the number I am going to give you is really a blend of the United States and Canada heavily weighted towards the United States, and it is for 1990. And what it showed is that $1,086 in 1990 of the cost of producing a North American vehicle was accounted for by dollars to support the U.S. health care system.

They did not have comparable data, but, to the best of their analysis, they looked at the difference between that level of cost and the level of cost borne by a firm in Japan and it well exceeded $500 per vehicle.

Now, trying to put that in perspective, keep in mind we are not talking about the total labor cost for a car, or the cost of building factories, or all of raw material, we are talking about what used to be called a fringe benefit for a worker, my company's total profits—total profits—have exceeded $500 per car only four times this century. So, I think this puts this matter in some perspective.

Senator RIEGLE. So, another way of saying that if we could get a health care system in place in this country that got these health

care costs equalized in terms of the burden falling on private companies between, say, the United States and Japan, you, in effect, would be saving that $500 per vehicle premium that you are now spending and that would be available for other things.

You could invest in new plants, you could train your workers, you might bring on new products, whatever it might happen to be. But that capital or that money would be available for some other use.

As you say, it exceeds the profit per vehicle that the Chrysler Co. has had in all but 4 years, I take it, this entire century. Is that right?

Mr. MAHER. That is right, Mr. Chairman. And, as Dr. Brailer mentioned, we cannot just raise our prices by $500, say we will just make that up in pricing——

Senator RIEGLE. Right. Right.

Mr. MAHER [continuing]. Because of the competitive market place we are in. And all that does is makes less dollars available, whether it is paid to people, whether it is invested in training.

And work force training in the technological changes that the manufacturing sector in this country is going through is very important. So, resources for employee training is critical to have available.

Senator RIEGLE. Now, let us just say a company had a $500 cost premium per vehicle and they did try to pass it on; just jack up the price of the vehicle another $500.

I would assume that there is enough price elasticity out there in terms of people shopping for vehicles that if you just jack up the price by $500, you are going to sell fewer vehicles, are you not?

Mr. MAHER. Yes. I think that is a very proper judgment on your part.

Senator RIEGLE. Would you not think so, Dr. Brailer? I mean, I sort of drew from what you said that you would not sell fewer vehicles in the short run.

Dr. BRAILER. Well, I can't answer as a consumer because it has been awhile since I bought a car, Senator. But, economically, an increase in cost would be expected to lower demand, so I guess that would be true. However, if I was a businessman and my cost per car went up $500 for some reason, I would start investing in more technology to reduce the labor input. So, I do not know how to separate the short run from the long run phenomenon this does not prove, however, that health costs do raise prices of autos.

Senator RIEGLE. Yes. Let me tell you how that is happening. Let me tell you one way that that is happening, as I view it. Heavy manufacturers in this country who have had a pattern of paying health insurance benefits and pretty good coverage plans, and so if they have a worker who has a spouse that is also working in a setting where they have a lower plan, normally the family would opt for the plan in the manufacturing sector.

Let me tell you what is happening right now just with respect to moving plants offshore to lower cost operating settings, of which there are a vast number available.

One such place where that is happening now is in Mexico, because Mexico is close in geographic terms. So, we have already had a lot of manufacturing plants already move to Mexico even without

a Free Trade Agreement. Now, if we have a Free Trade Agreement I think we will see a big acceleration of locations of plants to Mexico for the same reasons that they are now going.

But we have, just in the automobile industry over the last several years, there are some 70 or so Big Three plants that have gone to Mexico. Now, they are taking advantage, really, of three things in doing so.

They are taking advantage in lower labor costs, because the labor rates per hour are a tiny fraction of what they are here; they are taking advantage of lower environmental standards, generally speaking; and they are also taking advantage of the fact that along with the lower labor costs go lower fringe benefit costs.

So, there would be nothing even remotely approaching the health care burden in Mexico today for an auto worker or a truck worker down there than what is happening here.

So, in a sort of pure economic model, it is very easy to see when the cost picture becomes very severe and the squeeze is on and the pension managers across the country that hold corporate stock and so forth, they are applying the pressure to drive up earnings per share and drive down costs, and so forth.

What we are increasingly seeing are plant closings here in the United States and movement of facilities elsewhere, particularly, in this case, to Mexico.

Now, what is to stop that? Why will the economics of this puzzle, when you throw in the health care cost premiums on manufacturing in the United States, not be such that almost every firm, if it can take and consolidate and shrink its operations in America and move those, say, down to Mexico? Mexico is a specific case in point which is available and that which is quite close, and where they can off-load that health care cost and off-load some of these others costs.

Why are they not going to do that in increasing numbers? Why are they not doing that? In fact, I would submit they are doing that. I do not know if you have looked at that data, but why would that not be the incentive here?

Dr. BRAILER. Well, we have examined the question of offshore locations for various industries. We have not looked at the automobile industry. We found that one of the——

Senator RIEGLE. Why would you not have looked? I mean, that is the biggest item in our trade deficit. How could you miss that one?

Dr. BRAILER. We have had a problem getting data from the industry to look at that specific question. But, still, I think what we have learned from other industries applies to your question.

And the answer that I see is that if you look at the framework that I am setting for what competitiveness is of the economy, it is that the American public prefers a standard of living that is quite different than the Mexican public. It is not just health care costs, it is level of compensation, level of pension benefits, level of safety in the work place, et cetera.

And a businessman, in the short term, would certainly want to locate in Mexico because the balance there between what is necessary for the public and what is necessary for business perform-

ance clearly is skewed towards business. I think, luckily, in the United States, the public does not accept that.

Now, the issue about whether businesses should move factories to low-cost locations today does not address where the firm is going to be in 10 or 15 years, when they would want competent workers who are highly trained, and an ability to look at new markets.

Senator RIEGLE. Let me give you the answer. The answer is, as I see it—and it is a matter of great concern to me, that most of these corporations now in the country are multi-national companies, and they produce and sell internationally—their balance sheet and their income statement is that of an international business and not an American business, even if it happens to be born and raised in America, even with a predominant part of its operation still in America, they are international businesses. And, as a result of that, any disproportionate burdens that one carries here cannot be borne for very long.

I mean, you are seeing—and I do not know if this is coming back through the other studies that are going on at Wharton; I would hope that it is happening—is the pension management firms that more and more control very substantial holdings of common stock in this country are setting a performance directive and ethic that has absolutely nothing to do with employment in the United States.

I will tell you how extreme is has become. We just had a hearing about a month ago up in the Senate Banking Committee. We had Rand Arestah, who is the CEO of IT&T, come in to testify.

And he is obviously involved in the international economy, as other major company CEOs like himself are. And he voiced a view that he thought that American corporations should now set as a goal the creation of jobs in America.

I mean, I have not heard very many other people say that. It was almost like hearing a new language, because the whole power drive of the way the economy system is going today is to lower costs, however that can be accomplished, and widen out profit margins.

And, so, unless you can give me some evidence that I do not see for large, multi-national corporations as they maximize their strength for the future, it is awfully hard to see why they would necessarily care whether they have a manufacturing plant in America, in Japan, in Mexico, or some other place, as long as it is operating efficiently, perhaps is the low cost producer out there in that area of commerce internationally.

I see no reason why, in the absence of some other factor being introduced here, that they are going to stay and produce in the United States in order to stay the high cost producer.

And, you know, when Mr. Maher points out that in the case of just his company they are carrying something on the order of a $500 per vehicle cost premium just for health care, if everything else were equal—and, of course, it is not. If you can get Mexican labor for 50 cents or 75 cents an hour, versus the cost of American manufacturing labor which is several times higher than that, can you explain to me why an American company is going to stay here and produce and which American company it is that is doing that in the manufacturing sector. Because I do not see it.

Dr. BRAILER. I think if you look at factory location decisions in various industries, the amount of investment leaving the United States for other areas is not much larger than that from other countries entering the United States.

The total economic output of the factories that locate here from offshore producers is just a few hundred million dollars less than that which is currently owned by the United States in other markets.

I think that gives testimony to what you have already said, which is that we have an internationalizing economy, health care costs are part of that. But on the margin, the kinds of decisions that are made are not driven by health care costs, because, as even you recognize, the labor markets and other factors between the United States and other nations is not otherwise equal.

Senator RIEGLE. Well, on the manufacturing side, if you take out the Japanese, which is a special case because of the keiretsu arrangements and because Japan each year is running roughly a $43 billion trade surplus with the United States, if you take out Japanese investment and manufacturing here, particularly in vehicles which they have targeted heavily because it is an enormous bonanza for them, can you give me the data absent the Japanese investment there that would support what you have just said with respect to other manufacturing operations by other countries coming in the United States offsetting the movement of American manufacturers abroad?

Dr. BRAILER. I do not have the data on transparent import and export barriers here today, but it is still the total amount which is relevant.

Senator RIEGLE. Well, let me suggest to you, I do not think it exists. I mean, if you can find it, I will be happy to put it into the record. I think you find that when you X out what the Japanese manufacturing investment has been here—and that is, as I say, all tied up with their cross-connecting relationships in keiretsu where they are freezing out American companies,and supplier companies, and so forth, and so on—that is what gives you that data.

Dr. BRAILER. I agree, but the total flux remains the same.

Senator RIEGLE. Which, in a sense, presents a false picture. You pull that out, you will find that there is a net drain of manufacturing jobs out of the United States. I would assert even more than that that is accelerating, not decelerating. And I think it is a real danger.

It is a real danger, you know, whether it is to people coming in for inner city health care in Pennsylvania, or whether it is people some other place in our society. I think it is a real threat to the country, a real threat to our economic future. Mr. Maher, you wanted to make a point?

Mr. MAHER. Yes. That is an interesting point, Mr. Chairman. Because if a mature manufacturing firm in the United States decides to go and relocate to Japan, Germany, France, Italy, sets up a plant, hires a local work force, pays prevailing wages, their contribution to the health care system in that country is roughly on a par and identical in France to the industries in those countries. And they do not get a break because they have a younger work force or are generations away from their first retiree.

Conversely, a manufacturing firm from those countries come and sets up shop in the United States, hires a local work force, pays prevailing wages, offers comparable benefits, they have, because our system prices health care based on your use of the system, how young your work force is, by benefit of having a younger work force located in some corn field someplace——

Senator RIEGLE. No retirees.

Mr. MAHER [continuing]. Generations away from their first retiree, they have lower health costs, a very real cost advantage. And it is not something that they have earned, it is just a product of this country's health care system.

Senator RIEGLE. It is a walk-in. Yes. Yes.

Mr. MAHER. Now, 80 years from now maybe they will be here testifying about the problem. But short-term, it is not a problem. Therefore, I do not think——

Senator RIEGLE. It is not a problem for them. I mean, it is an enormous national problem for us.

Mr. MAHER. Therefore, if Dr. Brailer were able to come up and say, well, here are 14 firms that have set up shop in the United States, I do not think that that is an answer to this issue.

Senator RIEGLE. Yes. Yes, Mr. Moran.

Mr. MORAN. A second dimension of that, Mr. Chairman, that was alluded by both of the other witnesses here this morning and also by your earlier statement is that it is difficult to get at the reality of this just dealing with the averages.

The plain truth, as Dr. Brailer pointed out, is that to the extent that there is a subset of the American work force who is sufficiently more productive than other people elsewhere such that paying the higher cost of maintaining this lifestyle, sure, capital will come down from the moon to finance the operations of manufacturing and other industries in those circumstances, locate here and do it as they do.

The concern, I think, is the significant component of the U.S. work force that does not have the skills, does not have the background of whatever character that is required to meet the demands of where capital is being attracted.

And it is in those industries, particularly in those instances where you have semi-skilled manufacturing jobs in other areas, where the productivity differential is not there, which makes the cost differential very difficult, if not impossible, to bear. So, it is more distributive than that in the inside of our economy.

Senator RIEGLE. I must just say, and then we have got to move on to our other witnesses, the Chrysler Corp. made a very daring decision, and I think a decision very much in the public interest when it decided to build a state-of-the-art manufacturing plant in downtown Detroit, the Jefferson Avenue plant.

And it flies in the face of most of the conventional wisdom today in America in terms of major manufacturing operations. Most companies are not building new state-of-the-art plants, and if they are, they are not doing it in inner city locations, they are doing it out in the corn fields or some other place. Most of those plants, by the way, recently have been built by foreign companies coming in, hiring a younger work force, no retirees.

In the case of Japan, who is doing virtually all of it in automobiles, there is all of the keiretsu cross dealing, which I think is a direct violation of our antitrust laws. But that is a unique component to why they are coming and how they take advantage of the situation.

But, in the case of Chrysler, in building that inner city plant, I think you spent well in excess of a billion dollars to build it. It is a state-of-the-art plant, probably as sophisticated as any that exist in the world today.

And you kept an established work force. And, if memory serves me right, I think the average age of the worker in that plant is about 52 or 53 years old. Am I right about that?

Mr. MAHER. That is right. It is above age 50.

Senator RIEGLE. It is above age 50. And many of the workers in that plant either come from the city of Detroit or immediately adjacent to the city of Detroit.

And it is really a remarkable gamble, if you will. I think that from any public policy point of view, it is an enormously valuable decision that was made, and very important to our economic future.

But, built into that decision is this work force of a higher age, closer to retirement, the costs of that plus providing health care coverage in retirement, which Chrysler does, as the other automobile companies do, and so forth. There was every economic reason, separate and apart from just the public good of such a decision, to take and build that plant somewhere else.

They could have built it elsewhere in the country for less cost and walked away from that work force. You could have built it in Mexico, and I think I could demonstrate today just on the back of an envelope, enormous financial advantage to putting the plant in Mexico as opposed to putting it in downtown Detroit.

The problem is that, as spectacular as that individual plant decision was by Chrysler, there is almost no other examples of that happening in America, that I know of.

In fact, I cannot, from memory—and I read the papers carefully every day—think of another major manufacturing facility built in an inner city location with a work force with that profile and the health care cost premiums that go with it anywhere in the country. It is the only one I know about.

So, it is the exception that proves the rule. It was a terrific piece of decisionmaking by Chrysler; high-risk, good for the country, good for that community. But I do not find others like that going on.

I do not know of another plant location situation like that that would employ, I think there is in that plant probably 3,500 workers, or there about, something on that order.

I do not know of another example like that, because the country is moving off away from that, and business decisionmakers are moving away from that.

That is why when Arestah said the other day, voiced this notion that corporate CEO's ought to be thinking about how to create jobs in America, it sounded like a new language because it is almost a counter-culture message these days.

Because we are not creating more jobs in manufacturing, we are creating fewer jobs in manufacturing every single day; fewer, and fewer, and fewer.

And I think it is very dangerous to our long-run future because I do not care how many people we put in front of computer screens doing "service" type work. We cannot put enough people in front of computer screens to employ the country at a standard of living that will maintain the economic wherewithal of the country that we are accustomed to.

So, I see manufacturing under terrible pressure, in part, because of this unresolved health care situation. Every day that passes crushes, I think, more jobs in that sector of our economy. I think it diminishes our economic future; it leaves fewer and fewer jobs for people coming into the market to seek.

There was a story on television the other night of two veterans of Desert Storm a year ago, went over and wore the uniform of this country to defend the United States' interests and to carry our flag in that conflict.

They, obviously, with their colleagues who went over to participate, distinguished themselves. They came back, they received parades, which properly they should have.

And, in the instance of these two that were interviewed the other night on national television, they are unemployed and homeless, living in cardboard boxes. That is not an isolated situation.

I mean, we have got a dire situation with not enough jobs to go around in this country. And I do not just mean jobs at McDonald's that pay little more than what it takes just to survive each day.

I am talking about a job that pays a decent family wage and has with it decent retirement benefits and health care. Those jobs are disappearing in America. We do not have enough of them. We have fewer every single day.

That is why there is this terribly outcry out of Los Angeles right now, and it is not any different in most of the major other cities. We have got this huge under-class in the United States, people of all races, who cannot find work. There is no work to be had at any price—at any price, let alone at a decent living wage.

So, these huge structural inefficiencies that are killing jobs and driving jobs out of this country have to be dealt with. There is every humane reason to do it, but just the economic realities of the whole situation require us to get this health care system under control.

It is wrecking part of our economic system; it is wrecking part of our future; it is costing us jobs, and that just cannot be tolerated any longer.

Gentlemen, thank you very much for your testimony. It has been very helpful to us. Let me excuse the three of you now and call our last two witnesses on the last panel.

Let me now introduce Mr. Bruce Carlson, who is the director of health care programs for the James River Corp., which is a paper, pulp, and plastics consumer products company located in Richmond, VA; and also Mr. Milton Deaner, who is the president of the American Iron and Steel Institute. Gentlemen, we welcome you both.

Mr. Carlson, we would like to hear from you, first, and then from Mr. Deaner. We will make your full statements a part of the record, and feel free to summarize, if you would.

STATEMENT OF BRUCE E. CARLSON, DIRECTOR, HEALTH CARE PROGRAMS, JAMES RIVER CORP., RICHMOND, VA

Mr. CARLSON. Thank you, Mr. Chairman. My name is Bruce Carlson. I am director of health care programs for James River Corp. We are a paper, pulp, and plastics consumer products company headquartered in Richmond, VA. James River's 26,000 employees in this country are spread out over 30 States, with some 2,400 in Michigan.

We very much appreciate the opportunity to talk briefly about competitiveness and the way the ability of American business to compete is being shackled by the phenomenal rise in health care costs.

At James River, we market our Northern bathroom tissue, Brawny paper towels, and Dixie cups in all 50 States, and we sell our packaging and communication papers to a who's who of food companies and publishing companies, respectively.

We are not alone in those markets. And, in these tough economic times, competition in our business lines is downright cutthroat.

The times have mandated that we ration every dollar, and that is why we are so focused on our total employee medical costs that last year topped $80 million, with an additional $20 million for retirees.

To try to control these costs, we have instituted just about every cost management technique known: wellness programs; preventive benefits; preferred provider organizations; HMO's; utilization reviews; large case medical and psychological management; maternicall for pre-natal care; we have increased co-payments, deductibles, and premiums—a similar list of actions that many others in the nation have employed.

The result has been that we have been able to hold our employee medical costs at single-digit annual increases. But our employee health care management bag is about out of tricks.

None of our actions has been taken without pain. Over recent years, our management and labor unions have had numerous intense bargaining table discussions over health care issues.

In fact, things got so difficult that we saw a need to form a joint company union health care synergy team focused exclusively on finding common ground and common purpose around controlling health care costs.

One of the first things that our synergy team found was that it did not do any good to get mad at each other, because the health care problem we are facing was much bigger than the both of us.

And after a year of meetings, our group of ordinary businessmen and workers came to the inescapable conclusion that our American health care system is broken and desperately in need of comprehensive reform.

For our James River synergy team, the numbers say it all. Health care costs are at 13.5 percent of GNP, and headed to the 20's. American business spends nearly 50 percent of operating profits on medical benefits.

The only thing close to the percentage increase of health care is the increase in our National debt. And, as for competitiveness, the United States leads the world in both per capita spending on

health care, $2,354, and percentage of GNP spent on health care, 13.5 percent.

We spend 40 percent more than Canada; 85 percent more than France; 91 percent more than Germany; 127 percent more than Japan; and 181 percent more than Great Britain. Not only is the United States spending more for health care than the rest of the world, but we are not getting value for our money.

Comparing costs and an index of life expectancy, infant mortality and death from heart disease, the United States does not fare well against the U.K., Japan, France, and West Germany. These numbers make you wonder.

The answer lies in the fact that we have a fragmented Non-System. The problems that we see today are natural reactions to an inefficient system.

Over the past 10–15 years, our insatiable appetite to consume health care in the Nation has resulted in replacing the military/industrial complex with a medical/service complex.

Data has shown that the United States, with about 5 percent of the world population, spends almost half of the money in the world on health care.

And that spending has increased by more than 50 percent as a percentage of GNP growth since 1970. The growth of this medical service complex has occurred without the market dynamics and the demand and supply restraints normal to other sectors of the economy.

Further, it has been built using two-income streams: taxpayer dollars, and business and industrial dollars. Today, both streams have just about dried up.

Neither the government, nor the private sector, can any longer afford an unchecked health care delivery system. The government's $400 billion 1992 budget deficit and $3 trillion debt are known only too well to you.

But what people lose sight of is that it is American business that is the major provider of health and welfare programs to more than 80 percent of the population.

If American business continues to face increases in health care costs like those of the past 5 years, many will not be able to continue providing workers with medical benefits coverage.

And with so much of our population dependent upon business for their access to our health care system, reduction in coverage or elimination of coverage will reverberate throughout the land. This very real scenario is a ticking public policy time bomb. It needs to be defused now.

If we do not get the three-fold problems of soaring health care costs, limited access, and variable quality solved soon, it will not matter whether American business is competitive, or not.

As you are well aware, there are a number of groups here in Washington who are advocating various solutions.

Because it aligned with the principles we agreed were critical, the one our James River union/management synergy team has become affiliated with is the National Leadership Coalition for Health Care Reform.

I will not enumerate the Leadership Coalition's proposed reforms for excellent health for all Americans at a reasonable cost here, but they are detailed in the written text of these remarks.

The Leadership Coalition has developed a realistic and practical strategy and plan that is consistent with our James River union synergy team principles and has broad-based support. The plan is designed to optimize value and build off the strengths of our current health care delivery system.

I will close by simply saying that while some reforms have been put forth, reforms like those advocated by the Leadership Coalition enacted together, rather than in a piecemeal fashion, are the framework for a future American health care delivery system.

It is a system that we desperately need, because it would be one where an individual citizen's health will be considered among the rights to life, liberty, and the pursuit of happiness that have been our American heritage for 216 years.

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

Senator RIEGLE. Thank you very much. Before we move on, I have looked at what is laid out in the coalition plan's structured reforms that you have put out. In my view, they run along the same lines as what is contained in the bill that four of us have put out here in the Senate.

I think it is fair to say that your cost control section goes further than this bill does, and I am prepared to go further, myself, in what is contained in our bill. But would it be fair to say that the general outline of your approach is consistent with the general outline of what we put out here?

Mr. CARLSON. I think it is fair to say that the general direction is very similar.

Senator RIEGLE. Yes. Also, just before we move on, I was struck by your point—and you make it very graphically—about this being a ticking public policy time bomb.

It struck me the other day, if somebody was trying to hurt America, if somebody was really trying to hurt our economy, had that as their purpose to shrink the number of jobs and to impair our companies, our job base, and our economic future; if some foreign enemy, some group of strategists sat down somewhere in a closed room and tried to figure out, you know, what can we do to get America tied in knots so that America has a diminished future rather than a stronger future, you can almost follow that thinking to say that they would try to find a way in which, among other things, our health care system got out of control, that everybody just talked about it, nobody did anything about it, the costs became so burdensome that they began to crush companies, crush families, crush job creation. And if somebody outside our country had the purpose of trying to hurt America, it seems to me they would just be hoping that we would not do anything about this problem.

They would say America is being harmed by their current situation, let us just hope they do not change it. Because, you know, the faster they harm themselves, the more that it would suit the interest of some outside party that did not want America to do well.

It is almost that perverse. It is almost as if the failure to deal with a situation that is out of control can only hurt this country,

and, presumably, help others around the world who have the desire to gain an advantage in some way which increasingly they do.

I mean, if we have got a problem that is really working against our economic future, anybody that is a competitor around the world automatically gains by that. Do they not?

Mr. CARLSON. Yes, Mr. Chairman. I think that the status quo is truly unacceptable for our Nation. I think that other nations that do provide access and have limits on the amount that is spent in health care are at a competitive advantage as it relates to that particular aspect. And they can build off of the strengths of what they have done, to our disadvantage.

Senator RIEGLE. Mr. Deaner, if I am not mistaken, we have met before.

Mr. DEANER. Yes, we have.

Senator RIEGLE. With respect to McCullogh Steel in Dow River, MI. And I am pleased to have you here today. We would like to have your comments now.

STATEMENT OF MILTON DEANER, PRESIDENT, AMERICAN IRON AND STEEL INSTITUTE, WASHINGTON, DC

Mr. DEANER. Thank you, Mr. Chairman. I appreciate the opportunity to present the steel industry's concerns regarding the urgent need to enact comprehensive reform of our health care system.

There is no area that will impact economic growth more than our policy on health care. Our nation's health care system is the most expensive in the world, and will cripple our ability to compete in the world global market unless effective measures are taken, and the sooner, the better.

The American Iron and Steel Institute member companies and their steel-related operations provide health care benefits to over 800,000 employees, retirees, dependents, and surviving spouses—800,000.

Our member companies have provided health care insurance for more than four decades. But runaway health care costs are threatening the continuation of employer-provided health care.

Over the past 10 years, the U.S. steel industry has made significant progress in improving its competitive position. Productivity has doubled and quality has improved to world-class standards.

Employment costs other than health care have increased by only 21 percent since 1981, and steel sells today for less than it did 10 years ago. In contrast, our members have experienced a 177 percent rise in the cost of health care in this same timeframe.

Today, our member's annual health care bill exceeds $1 billion, or over 15 percent of the total employment costs. And health care costs show no signs of moderating, despite our many efforts to control cost.

This cost is becoming an increasingly important factor in limiting the U.S. ability to compete in global markets.

For example, Bethlehem Steel corporation recently reported that health care costs about $25 per ton on products that sell for less than $400 per ton. Several recent studies confirm that among our major trading partners, the United States has the highest per capita health care costs.

For example, in 1991, the U.S. steel industry's health care bill for employees and dependents totalled approximately $8,680 per active wage employee; $8,680 per active worker.

Senator RIEGLE. That is just for the insurance coverage for 1 year.

Mr. DEANER. That is correct; $8,680. If you made $20,000, it would not leave much, would it? In Canada, the next highest cost nation, that figure is approximately $3,600.

This is a significant cost difference for basically the same benefit package, and the difference is even more dramatic in comparison to our major foreign competitors.

Because steel is an international commodity and U.S. companies must compete in the global market, this cost differential is simply not sustainable in the long run.

The cost of uncompensated care for the uninsured is recouped by health care providers through increased prices and premiums charged to the insured patients. Cost shifting to the private insurers by the much larger public plans compounds the problem, and you have heard that from all of us today.

Now, the AISI supports comprehensive reform efforts that will address costs, quality, and access. Unless costs, quality, and access to care are acted on, the health care crisis will worsen.

The AISI has developed the following six recommendations. First, public and private payers should pay the same for health care, and by establishing negotiated regional reimbursement schedules for hospitals and physicians, the additional cost shifting from the already large public programs to the private employee should be eliminated.

Second, national spending targets should be established. This will help control increases by forcing more careful decisions regarding the introduction and over-utilization of technology.

Third, medical practice protocols and quality measurement systems should be developed to improve the quality of health care and to aid in technology assessments.

Fourth, medical malpractice reform should be initiated to reduce incentives for law suits and avoid the grossly disproportionate rewards.

Fifth, Medicare must remain the primary payer for the elderly and should be expanded to replace the less efficient Medicaid program.

Sixth, employers should be encouraged to provide basic health care benefits, thereby extending coverage to all workers.

These recommendations are offered as the basic elements for comprehensive reform of our current system to control medical costs. This will also permit our Nation to provide millions of nonworking individuals access to a more efficient health care system.

Recently, the National Leadership Coalition for Health Care Reform, which represents a range of companies including steel, announced its comprehensive plan. And the plan incorporates these six important elements, and, therefore, we support it.

Mr. Chairman, we look forward to working with you and other members of Congress to enact urgently needed comprehensive reform. From the business point of view, no proposal is acceptable that will not control health care costs, assure Americans of cov-

erage they need, and spread the economic burden of paying for the coverage more fairly than the system we now have.

I thank you very much for allowing me to come this morning.

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

Senator RIEGLE. Well, we are pleased to have you, and I appreciate your testimony. You indicate that in the steel industry today that there are about 800,000 employees that are working there and covered by health insurance. Am I right on that?

Mr. DEANER. 800,000, including, of course, their families, and retirees.

Senator RIEGLE. And their families. Exactly. Now, let us say we lost, over the next 2, 3, 4 years, half of those jobs. God forbid that we do, because we need every last job that we can find.

But let us, just for the reason of the hypothetical that I want to pose to you, let us say that we lost half of those jobs and the industry went down from 800,000 people covered with health insurance through jobs in the steel industry to, say, 400,000.

Now, those 400,000 that were no longer covered would not, by and large, just disappear from the scene, they would be out there in our society. They would have to try to get their health care some other place. If they could not find another job, either the wage earner or the dependent of that wage earner, they cannot find another job that offers health insurance, then they would not have any health insurance, would they?

Mr. DEANER. They would not.

Senator RIEGLE. And, then, if they get sick, they either have to spend what savings they may have—most people do not have much savings. And, then, if that is exhausted, then they go on public assistance and they would be eligible on the basis of a finding of poverty to be eligible for Medicaid assistance.

So, if that unfortunate train of events happened, they would finally get some care. But who would pay for that? If they ended up going on Medicaid, who ends up paying for that care?

Mr. DEANER. Well, a disproportionate share is going to shift back to those who pay. And that means this $8,680 becomes a much larger number. Also, in downsizing, we cover so many workers who are not working.

And there will come a point that that simply cannot be done because we are competing economically with countries, and we are talking about a product that sells from $250 to several hundred dollars. It is not a high-priced product.

Senator RIEGLE. Well, it seems to me that two things happened. If we saw this industry cut in half and it has been shrinking in terms of number of people, as you well know, if that continues, what is going to happen is that the costs to cover the people and their dependents who lose their jobs and cannot find health insurance, they are either going to come under welfare coverage under Medicaid, in which case, everybody in the country is going to have to pay for it. So, it is not as if it is not going to have to get paid for. It is just going to have to get paid for by somebody else.

But then, also, because of the strange way in which we move these costs through the system, it is going to jack up the rates for everybody else who is paying insurance who does have coverage,

whether they work in the steel industry or they work somewhere else.

They are going find their rates go up because some of the costs for Medicaid that are not covered get shifted through the system and land back over on the person who does have private insurance.

It is another way of saying that nobody in society who has a job and who has health insurance is going to escape the extra burden and the extra cost of the family and worker that loses this coverage if we continue to lose our job base and we continue to lose our private sector coverage of health insurance.

In other words, what will happen is that that person out there without any health insurance coverage eventually is going to be overtaken by health problems.

Oftentimes they go to the doctor or hospital late, so their problems are worse and they are in far worse medical circumstances. The costs tend to be much higher. But those costs come piling right back in again.

And either we all pay part of them as taxpayers into our government for Medicaid, or some of those costs will be shifted around and land on the other private insurance people so the companies and the individuals who are buying insurance are going to find their rates keep going through the ceiling, whether they are even using medical insurance or not.

They may have it and not even file any claims, and find next year that their rates have gone way up because they have got to carry the additional burden of people who are in the category that I just described. The system is breaking down on us right now.

We cannot afford to lose one more job in the James River Corp., and we cannot afford to lose one more steel job in this country. In fact, we have got too few already. We need to be growing jobs.

We need to have your company expanding, your industry expanding. We have got 16 million people in the country right now looking for work and cannot find it. I would like some of them to be able to come find some additional jobs in the paper industry, or some additional jobs in the steel industry.

But, right now, the dynamics are cutting just the other way, in part, because of this horrendous burden of health care costs that we have not faced up to as a country. We have not agreed to sit down and work the thing out.

I am convinced we can do it. And I say that because we have thought it through. We have put forth a proposal that we think is one way of doing it.

But every other country has found a way to do it. I mean, we are the only country right now sitting around scratching our head about this problem and not doing something about it.

Every other country has done something about it. They have undertaken a plan to try to do this, in part because they want their people healthy, but they also want their business sector healthy. They want the jobs, and wisely so.

And we are the country right now where we have got a problem with not enough jobs, and not enough jobs in the kinds of industries that you represent which are jobs that pay middle class incomes, pay retirement benefits, have good health care coverage. That is what people want.

We do not want to lose those jobs and end up getting minimum wage jobs or in the service industry where people do not get any health care coverage, may not get any retirement, and just make enough to sort of eke out a bare living day in and day out; not one that can support a family, buy a house, save money for a child's education, and so forth.

So, it seems to me that what you have said lends greater urgency to the need to find an answer to this, not postpone it past this election.

If it gets postponed past this election, do you know what will happen? There is another election in 2 years. Then there is another election 4 years from now. I mean, there is always an election. There is always an election to put things off until you get past the next election.

If we do that we will be into the year 2000 and we will still be waiting for plans from people and not have them. So, I do not think we should wait any longer. I think we should try to do it this year.

Am I correct in assuming that you all feel that we have got to have some kind of a comprehensive national health expenditure board, or something that would carry a similar name, that would sit down around the table the key buyers and sellers of health care to have a head-on negotiation and discussion by which we would go through a process of that sort to determine what rates can be paid for our basic medical services and care in this country?

Mr. CARLSON. Yes, Mr. Chairman. We support that type of an approach. I think it is incumbent upon us to develop that through a public/private partnership.

Senator RIEGLE. Do you feel that way, Mr. Deaner?

Mr. DEANER. Absolutely. If I may comment a little. You indicated earlier about our foreign competitors. I am certain they are delighted with the system we have.

Senator RIEGLE. They hope we do not fix it.

Mr. DEANER. Right.

Senator RIEGLE. They do not want us to fix it.

Mr. DEANER. And they can project, as well as anyone else, from $8,600 where we are going if something is not done. The other point, just for one moment, during my earlier days at McLouth Steel Corp., you had a study done at the University of Michigan and it showed that for each steel worker there are four workers in supporting industries that are dependent on him.

Senator RIEGLE. Right.

Mr. DEANER. And this industry has gone from about 600,000 employees to close to 160,000 employees. So, you use the multiplier, and you can see what a huge number that are affected by this industry.

Senator RIEGLE. I will give you another illustration of that that is current right now. The General Motors Corp. has just announced in Michigan that it is going to be closing two major manufacturing plants. One is the Willow Run plant that has been in the news, the other is an engine plant in my home town of Flint, Michigan.

There are about 8,000 workers that will lose their jobs as a result of those two plant closings that are now announced. There are another roughly 2,000 workers that are going to be displaced in other GM locations around Michigan that do not involve an entire

plant closing. So, in total, the job eliminations from that GM announcement are about 10,000 jobs.

The UpJohn Institute in Michigan has done a study as to how many other jobs, indirect jobs that depend upon these GM jobs, will also be lost. This is what they found. They found that for every one of these GM manufacturing jobs that disappears, that we are going to lose another 5.5 jobs just in the State of Michigan.

So, when General Motors eliminates those 10,000 jobs, the UpJohn Institute tells us that another 55,000 jobs at the same time will also disappear. If you add that up, that is 65,000 jobs disappearing in just one State at a time when we need jobs. I mean, we need more jobs, not fewer jobs.

So, you are exactly right. The multiplier effect when you lose these basic manufacturing industry jobs, you not only lose that worker, but you are losing other workers in the community whose livelihood depends upon that worker staying employed.

But I appreciate the fact that you both support the idea of a national health expenditure board, because that has to be done.

The final question is this. Some say this problem is so big and so tough, that instead of tackling the whole thing at once and dealing with it in a comprehensive way and putting in some cost controls and really getting this situation re-engineered so that we have got a solid national working system, that what we should do is do it piecemeal. The phrase that is used is "incremental change."

In other words, find a piece of the problem, chip that off, try to make an improvement in that area. Then, move ahead, find another piece of the problem, chip that off, try to do something in that area. Then go find, next, another piece of the problem, chip that off, and do something in that area.

When I look at those two alternatives, I think we are a decade late already in dealing with this problem and I am inclined to believe myself from the work we have done that the incremental approach is just wrong.

The problem is too big. It needs a major overhaul. We ought to sit down and crack the whole thing apart, re-engineer the whole thing, and go in that fashion.

But what is your reaction to taking it piece by piece over a period of time versus taking the whole thing on at once?

Mr. CARLSON. I do not think we can afford to attack it piecemeal. Band-aids just will not work. I think we have learned during the last decade that the system has perverse incentives in it at this point. The problems we are seeing will continue and, perhaps, will be exacerbated if we address certain segments of the system.

Senator RIEGLE. Mr. Deaner.

Mr. DEANER. We do not have time to piecemeal it. We need to get on with a comprehensive program, as I have outlined.

Senator RIEGLE. Gentlemen, thank you very much for your testimony. It has been very helpful. That, and the other witnesses. We will be continuing these hearings again on a future date very soon, and we thank you all for participating. The committee stands in recess.

[Whereupon, the hearing was concluded at 12:19 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF DAVID J. BRAILER

Over the past three years, researchers at the Wharton School have studied health care spending and the competitiveness of United States industry in world and domestic markets. This work has been performed with advice from and support of the Huntsman Center for Global Competition and Leadership at the Wharton School, the National Association of Manufacturers, and other organizations. Our principal goal is to help industry leaders and policy makers define the role that business should play in the delivery of health care for employees, including internal health benefit management and external public policies related to this issue.

This research consists of several economic studies of health cost management at the industry and firm level, multinational comparison studies, on-site case studies, and internal management analyses, which will be summarized here. Because the data available to support firm conclusions from this research is limited, caution should be exercised when interpreting these findings. Our research and my testimony today are not intended to advocate specific ideologies for reform, but to set a framework in which we can better understand health care spending and competitiveness.

The central thesis of our work is that health care costs do have an impact on the competitiveness of our economy. However, the short run effect of health care spending on our national competitiveness arises not from declining business market shares or slowed global expansion, but from the threat to the standard of living of the American public. In the long run, our work suggests that business performance may decline as well. Health care reform is important for these reasons and for many other reasons as well.

Many business leaders attribute the competitive problems they face in world markets to rising health benefit costs. This view links the rise in health costs to higher labor costs that, in turn, are linked to higher output prices. Indeed, it is well known that health care costs paid by U.S. employers have risen dramatically since 1970, and that the United States ranks higher than any other nation in per capita health care expenditures. However, the linkage between health care costs and final product prices—the basis for competition of equivalent goods—is not clear. Most rigorous investigations about this topic in the past thirty years have not shown that the mix of labor costs (such as wages, health benefit costs, and pensions) affects final prices in a material way. Rather, a change in any single labor cost tends to adjust the others such that total compensation remains unchanged.

The issue of health care costs and the competitiveness of U.S. firms is historically controversial and has taken on renewed importance because many industrial firms are justifying their support for health care reform on this basis. The active support of business executives for health care reform is encouraging, and those who have emerged as leaders of this issue have much to offer. However, this justification for support obscures the importance of this issue to the public, singles out health care as an isolated unique cause of competitive problems when it is one of many infrastructural problems facing business, and fundamentally ignores the role business should play in managing the delivery of health care for its employees now and in the future.

Business leaders appropriately view their competitiveness in terms of market share or corporate performance, which results in their concern about the magnitude of health benefit costs relative to operating costs, output, or profits. This definition of competitiveness is insufficient for evaluating the larger economy, however, because it does not reveal the effects of a firm's current behavior on its future perform-

ance, and because a firm could expand rapidly by shifting costs to the public sector or to its employees.

A broader view of economic competitiveness would consider not only the current performance of U.S. firms in global and domestic markets, but also the long term ability of U.S. firms to compete and the standard of living of U.S. citizens at home. Economic competitiveness captures the essential balance of the citizenry and industry that must occur in order for both to prosper. This perspective underlies our research, and is the competitiveness definition of several policy groups within and outside the government.

We have found that the American public is paying for health care costs in the form of higher prices charged by some industries, lower wages paid by some industries, and elimination of health benefits by other industries. It is not surprising that, in the end, the public pays for this social good; however, the mixture of wages and higher prices raises the prospect that real income is declining relative to prices, and suggests that industries respond differently to rising health care costs.

Firms in autarkic industries—such as service operations, hotel and travel services, public agencies, and financial companies—pass on health care costs in their prices or user fees. Because there is no lower-cost competitor in these markets, the American public pays for these costs through higher prices for goods and services, some of which are "essential." Firms in stable globalized industries—heavy manufacturing, electronics, or chemical companies—offset health care benefit costs with decreases or slower growth in money wages and do not exhibit price increases driven by health care benefit costs. These firms operate in markets that became heavily competitive and globalized in the past, which may explain the flat real wages in the U.S. since 1970 and support the suggestion that real wages have fallen in the U.S. since 1987. Of course, some firms—particularly small firms, retailers, construction, and seasonal firms—reduce the level of health care and other benefits offered to employees or reduce the number of employees covered without adjusting wages, creating the well-documented pre-recession working uninsured population of over 18 million persons.

The net effect of these different industry-specific responses to high health benefit costs is that the American public pays higher prices for some goods and services, receives lower wages in many labor markets, and receives lesser quality and eroding health benefits from some employers. Thus, regardless of whether health care spending affects American business performance, it directly affects the real income of many Americans. This, in itself, does not imply a competitiveness problem, because we do not know the degree to which the growth in health care technology and capacity is valued by the public. However, if the perceived value of health services is not increasing at a rate commensurate with this loss of income, or if the public prefers more of some other good or service more than health care but cannot afford it, then the standard of living of the U.S. public is indeed falling.

The corollary of this finding is that because most industries pass their health benefit costs on to the public in some form, there does not appear to be an aggregate industrial competitive problem related solely to health care costs. More important than total cost is the rate of growth and the inability of business to make accurate projections about future health benefit costs. Our research suggests that the level of health benefit costs themselves are not a significant factor in overall industrial output prices or in relative prices of U.S. output compared to our top global competitors. Over the entire industrial economy, no conclusive evidence exists that health care costs are harming the overall U.S.-held share of trade in domestic or global markets.

The current financing of health benefits may aid some industries, particularly those that sell health care products or technology. It is possible that these firms gain comparative advantage through transparent barriers in the U.S. market and transform domestic performance into global expansion. Indeed, many of these industries are net exporters, having posted a $3 billion trade surplus in 1990. There are benefits to the economy beyond the trade surplus. For example, these industries create technology that can diffuse into applications in other productive industries. On the other hand, it follows that if some industries derive benefit from the current health care system, others may be at a disadvantage because of it.

Indeed, although most of our work is aimed at the aggregate and industrial level, do not suggest that specific firms or industries are not harmed by current health care benefit costs and management practices. As previously described, industries which faced globalization in the past and autarkic industries, for which globalization is not an issue, appear to have mechanisms for disposing of health care costs which keeps them efficient. However, other industries, such as automobile manufacturing, face a late and rapid transition into globalized markets attributable primarily to import penetration into the domestic economy. These industries have historically oper-

ated with inefficiencies such as higher wages or lower labor force productivity, in addition to higher health benefit costs, but now face intense cost and quality competition. In this setting, the health benefit cost is but one of many high costs facing these firms, and the health care reform debate does not give justice to the strategic role of these firms or the multiple dimensions of their competitive problems. It is also doubtful that health care reform will, in itself, relieve the competitive pressures these industries now face.

Our research suggests that while health care costs paid by American businesses do not affect their trade performance per se, these firms may be at risk in the future because the current practice of health benefit management could place their core competence in jeopardy. For example, health care benefit costs are a well-known issue in labor-management disputes. Although many issues may underlie strained labor-management relations, a dispute over the costs of health benefits can harm a firm's competitive performance by diminishing the stability, technical growth, and quality management of the firm. Likewise, when firms offer health benefits packages with faulty assumptions about the endemic rate of health plan cost growth, downstream costs that exceed these projections have to be-funded from other sources. One source of funds is that allocated for employee training or research and development, which are both key components of becoming globally competitive. Similarly, if decisions regarding offshore location decisions or supply chain and outsourcing decisions are determined on the margin by the cost of health benefits, a seemingly correct business decision could harm future skills, innovation, or growth.

Regardless of the outcome of the health care reform debate and the shape of the system that may result, employers will likely have a prominent role. However, unlike in the past when employers accepted provider monopsony and the structure of the provider market, they must redefine their role in the future to become responsible, committed buyers of health care services for their employees. To accomplish this, businesses should reorient themselves toward value rather than cost alone, rejuvenate coalitions to concentrate buying power, and work with providers to reform local markets. Through mechanisms such as these, firms can avoid the harmful effects created by rising health costs and by their management of these costs. Federal policy can aid this process by clearing hurdles to this activity, eliminating market segmentation and public and private cost-shifting, encouraging competition in health care techno'ogy markets, and by providing incentives for businesses to be better buyers.

At present, the key issue is not that health care costs prevent businesses from winning head-to-head price competition in world markets, but that increasing health costs and the current manner in which they are managed by firms makes it difficult to train workers, invest in new innovations, cooperate with labor, and do the other things that are necessary to compete in world markets, now or in the future. Health care reform is necessary for this reason, among many others. Although the standard of living of Americans appears to be of greater concern than the threat to business performance today, in the future, both the standard of living of our citizens and the performance of U.S. businesses may suffer without health care reform.

PREPARED STATEMENT OF BRUCE E. CARLSON

Mr. Chairman and Members of the subcommittee: My name is Bruce Carlson, and I am Director, Health Care Programs, for James River Corporation, a paper, pulp and plastics consumer products company headquartered in Richmond, Virginia. James River's 26,000 employees in this country are spread out over 30 states, with some 2,400 in Michigan.

We very much appreciate the opportunity to talk briefly about competitiveness and the way the ability of American business to compete is being shackled by the phenomenal rise in health care costs. At James River we market our Northern bathroom tissue, Brawny paper towels and Dixie cups in all 50 states, and we sell our packaging and communication papers to a Who's Who of food companies and publishing companies respectively. We are not alone in those markets. And in these tough economic times competition in our business lines is downright cutthroat. The times have mandated that we ration every dollar, and that's why we are so focused on our total employee medical costs that last year topped $80 million, with an additional $20 million for retirees.

To try and control those costs we have gone through the same list of actions that the nation has employed. We've instituted just about every cost management technique: Wellness Programs; Preventive Benefits; Preferred Provider Organizations; Health Maintenance Organizations; Utilization Reviews; Large Case Medical and

Psychological Management; Maternicall for Pre-Natal Care; Increased Co-Payments, Deductibles, and Premiums—a similar list of actions that many others in the nation have employed. The result has been that we've been able to hold our employee medical costs at single-digit annual increases, but our employee health care management bag is about out of tricks.

None of our actions has been taken without pain. Over recent years our management and labor unions have had numerous intense bargaining table discussions over health care issues. In fact, things got so difficult that we saw need to form a joint company-union health care synergy team focused exclusively on finding common ground and common purpose around controlling health care costs.

One of the very first things our synergy team found out was that it didn't do any good to get mad at each other because the health care problem we were facing was much bigger than the both of us. And after a year of meetings our group of ordinary businessmen and workers came to the inescapable conclusion that our American health care system is broken and desperately in need of comprehensive reform.

What puzzles us is, if we can figure that out, why can't Congress?

For our James River synergy team, the numbers say it all:

- Health Care costs are 13.5% of GNP and headed to the 20s
- American Business spends nearly 50% of operating profits on medical benefits
- The only thing close to the percentage increase of health care is the increase in the National Debt.

And as for competitiveness, the United States leads the world in both per capita spending on health care—$2,354, and percentage of GNP spent on health care—13.5%.

We spend 40% more than Canada, 85% more than France, 91% more than Germany, 127% more than Japan and 181% more than Great Britain.

Not only is the United States spending more for health care than the rest of the world, but we're not getting value for our money. Comparing costs and an index of life expectancy, infant mortality, and death from heart disease, the United States does not fare well against the U.K., Japan, France and West Germany. These numbers make you wonder.

The answer lies in the fact that we have a Non-System. Over the past 10 to 15 years our insatiable appetite to consume health dare in the nation has resulted in replacing the Military/Industrial Complex with a Medical/Service Complex. Data has shown that the United States with about 5% of the world population spends almost half of the money in the world on health care, and that spending has increased by more than 50% as a percentage of GNP growth since 1970. The growth of this Medical/Service Complex has occurred without the market dynamics and the demand and supply restraints normal to other sectors of the economy. Further, it has been built using two income streams—taxpayer dollars and business and industrial dollars. And today both streams have just about dried up.

Neither the government nor the private sector can any longer afford an unchecked health care delivery system. The government's $400 billion 1992 budget deficit, and $3 trillion debt are known only too well to you. But what people lose sight of is that it is American business that is the major provider of health and welfare programs to more than 80 per cent of the population.

If American business continues to face increases in health care costs like those of the past five years, many won't be able to continue providing workers with medical benefits coverage. And with so much of our population dependent on business for their access to our health care system, reductions in coverage, or elimination of coverage, will reverberate throughout the land.

This very real scenario is a ticking public policy time bomb. It needs to be defused now. If we don't get the three-fold problems of soaring health care costs, limited access and variable quality solved soon, it won't matter whether American business is competitive or not.

As you are well aware, there are a number of groups here in Washington who are advocating various solutions. Because it aligned with the principles we agreed were critical, the one our James River management/union synergy team has become affiliated with is the National Leadership Coalition for Health Care Reform. The National Leadership Coalition advocates a comprehensive reform of our nation's health care delivery system.

The Leadership Coalition has developed a realistic and practical strategy and plan that is consistent with our James River/Union synergy team principles, and has broad based support. The Plan is designed to optimize value and build off the strengths of our current health care delivery system.

The Leadership Coalition is an organization of organizations: consumer and provider groups like the American Nurses Association, the AARP, and Families USA,

and large and small businesses in various industries. This group came together understanding that the health care delivery system is in crisis. It recognizes that the need for reform is urgent, and the private sector (individuals and companies), who pay most of the nation's health care bills, should, and need to, help craft the solution.

In our view, the structure of the health care delivery system in the United States is inherently flawed. In fact, it's a non-system where the typical laws of supply and demand have not worked. As William Hsiao wrote in the New England Journal of Medicine recently:

> "The market for physicians services does not satisfy the conditions that define a reasonably competitive market . . . physicians are often not subject to the checks and balances generated by traditional competitive forces . . . legal restrictions specify who can provide medical services, admit patients and prescribe drugs. Although such restrictions protect patients from unqualified providers, they also tend to grant monopoly power to the medical profession."

We have no desire to single out any one party as being responsible for the health care delivery crisis facing the nation. The problem is big enough to spread blame all around. But, we are looking to the providers to deliver high quality care, control utilization, and contract with those who are efficient and capable of controlling their internal cost structure.

This task is, we feel, too big for individual localities and states to do by themselves. Health care is an issue unlike any other: the objective is simple, but the stakes are huge and arriving at a solution is enormously complex. Nonetheless, we feel those objectives are encompassed within the principles and plan of the National Leadership Coalition for Health Care Reform.

The Leadership Coalition Plan has a very straight forward purpose—to ensure a healthy society for all Americans. The Plan has eight interdependent elements which reinforce each other:

1. **QUALITY.** The first step is to standardize and clarify what quality health care is . . . and is not. The Plan calls for the formation of a National Board of Health Care Quality, made up of representatives from the public and private sectors, whose mission would be to develop medical practice guidelines and define what is appropriate and efficient health care.

The Board would classify and disseminate the best information on alternative technologies and treatments and would strive to help health care professionals and patients make better informed decisions and provide higher quality, less variable care.

The Board would fund new research on the effects of new technologies and treatments and would coordinate the flow of information through a national data bank to allow providers more access to the latest and most effective methods of care. Such information would be used in decisions regarding health care payments, and would serve as standards to be applied against malpractice.

2. **ACCESS.** The Coalition seeks to open up medical coverage to all Americans through their coverage at work, through individual overage, or through a new comprehensive program called "Pro-Health" that would include incorporate Medicaid.

The Pro-Health plan would be paid for by all employers contributing one half of one per cent of payroll and all employees one half of one per cent of payroll. If the employer offers a plan comparable to the Pro-Health coverage, there would be no further financial obligation. On the other hand, if the employer did not offer a comparable plan, it would pay seven percent of payroll to Pro-Health, matched by a participant's contribution of 1.75 percent of pay.

3. **COST CONTROL.** Without cost controls any health care system is doomed to failure. The National Leadership Coalition's strategy calls for a new, public private National Health Review Board that would set an annual target for health care expenditures. The Board would consist of representatives of health care providers, payers, consumers and government. Its target would be to reduce health care growth by two per cent a year until it matches the growth of GNP. From then on health care growth would be kept at no higher than that of GNP.

The second element of cost control is the establishment of payment rates for all providers of health care services, similar to that of the Medicare system. In essence the idea is to extend the Medicare approach to the private sector. The Board would set rates at levels calculated to yield overall health care spending no higher than the annual expenditure target.

The final element of cost control would be the establishment of a national target for capital spending, again through a process similar to that presently used for Medicare.

4. **ORGANIZED DELIVERY SYSTEMS.** We need one stop health care provider organizations that would be responsible, all under one roof, for a whole continuum of services, including outpatient, inpatient, and long-term care. In order to make it attractive for such ODSs to form, they would be exempt from the new rate-setting system implemented by the National Health Review Board.

The ODSs would compete on their ability to manage the quality and efficiency of care provided to those they serve. They would be held accountable by their clients—Pro-Health, large employers or groups of small employers and individuals. In this system some will succeed . . . and some will fail . . . but all will compete.

5. **MANAGEMENT AND OVERSIGHT.** The Coalition Plan envisions that the National Health Review Board will be responsible for managing and overseeing our national health care delivery system by setting the annual expenditure target, updating payment rates, and recommending modifications in the standard benefit package. Meanwhile the States would each be responsible for administering their own health care spending budgets and managing the Pro-Health program at their level.

6. **INSURANCE REFORM.** A special focus of this strategy is small business and the elimination of those insurance practices that price small business out of the health coverage marketplace.

To encourage more small businesses to provide health coverage for their employees, each insurer would be required to:

—offer small groups the standard benefit package and accept all groups that seek health insurance in the geographic area served by the insurer;
—set premiums on the same terms, with a return to community ratings, for all groups in an area;
—renew all policies with premiums adjusted on an area-wide, not firm-by-firm, basis.

Additionally, all state mandates would be eliminated!

7. **MALPRACTICE.** A critical part of any reform of our national health care delivery system is malpractice reform. As a way to encourage Organized Delivery Systems to monitor quality closely, the National Coalition's plan would hold the ODSs responsible for malpractice, not individual doctors. When their pocketbooks and reputations as quality providers are on the line, there will be less tolerance for malpractice.

Other malpractice reforms cited by the Coalition include adopting a new recredentialling system for health care professionals that involves periodic re-examination of their patterns of practice; conducting demonstration projects to test the impact of alternative malpractice dispute resolution; and, caps on legal fees and malpractice awards.

8. **ADMINISTRATIVE SIMPLIFICATION.** The health care delivery system in this country is rife with complexity. Our Coalition Plan calls for standard benefits package, uniform rates, a single claims form, increased use of electronic billing . . . all of which will lead to a system more easily understandable to all who use it.

In closing, at James River Corporation we have been scrutinizing the health care delivery system in the United States for several years. Thus, we truly understand that total system reform won't be easy. Such reform requires change, and change is never easy.

But our years of study of the health care delivery system also taught us something else: the system that has developed over the last 50 years is fatally flawed and broken. To continue the status quo is unacceptable. The responsibility to cure the system rests with each individual American and each special interest group to rise above selfish concerns and craft an American solution that provides an American system to take care of an American right: the right to health wherein each of us can pursue life, liberty and happiness.

PREPARED STATEMENT OF MILTON DEANER

Mr. Chairman, I appreciate the opportunity to appear today to present our concerns and recommendations regarding the urgent need to enact comprehensive reform of our nation's health care system. There is no area that will impact our future economic growth more than our policy on health care. Our nation's health care system is the most expensive in the world and will cripple our ability to compete in the global economy unless effective and comprehensive measures that address cost, quality, and access are taken.

American Iron and Steel Institute member companies produce about 75% of our country's raw steel and through their steel-related operations provide health care benefits to over 800,000 employees, retirees, dependents, and surviving spouses.

Our member companies have provided health insurance coverage for more than four decades. But runaway health care costs are threatening the continued viability of existing employer-provided health care programs. Over the past 10 years, the U.S. steel industry has made significant progress in improving its competitive position. Productivity has doubled and quality has improved to world class highs with introduction of new steel-making technology and more efficient human resources management. Other employment costs have been carefully controlled so that our wage costs—exclusive of health insurance—have increased by only twenty one percent since 1981.

In stark contrast, our members have experienced a 177% rise in the cost of health care benefits in the same time period. Today, our members' annual health care bill exceeds one billion dollars; and, at the current rate (February, 1992) of $4.42 per hour worked, accounts for over fifteen percent of total employment cost.

And, health care costs show no sign of moderating, despite the increased use of deductibles, copayments, preadmission certification, second surgical opinions, and aggressive managed care and HMO/PPO arrangements. Consequently, this cost is becoming an increasingly important factor limiting the U.S.'s ability to compete in the global market. For example, Bethlehem Steel Corp. recently reported that health care accounts for six percent of its total production cost, or $25 per ton that is not available for necessary investments in plant and equipment, research and development, and employee training.

Several recent studies confirm that, among our major trading partners, the U.S. has the highest per capita health care cost. In the U.S. this cost is borne principally by the larger employers. Whereas in Canada, Europe, and Japan, the cost of health care is spread more equitably among all employers and/or the public. For example, on an annual basis, the U.S. steel industry's health care bill for employees, retirees and their dependents totalled approximately $8,680 per active employee in 1991. In Canada, the next highest cost nation, that figure was approximately $3,600.

This is a significant cost difference, particularly when you consider that steelworkers in the U.S. and Canada have basically the same benefit package. The difference is even more dramatic in comparison to our major European competitors. Because steel is an international commodity and U.S. companies must compete in the global market, this cost differential is simply not sustainable in the long run.

Uncontrolled costs are also pricing health care out of reach for many small employers. More than thirty million Americans are without health insurance coverage and, as health care costs escalate, more are losing insurance protection every year. The cost of uncompensated care for the uninsured is recouped by health care providers through increased prices and premiums charged to insured patients. Cost-shifting to private insurers by the much larger public plans compounds the problem for all employers.

AISI supports comprehensive systemic reform efforts that will address cost, quality, and access. These three critical elements are interdependent; unless all three are soon acted on with an integrated plan, the health care crisis will worsen.

Therefore, AISI has developed the following six recommendations:

—First, public and private payers should pay the same for health care. By establishing regional reimbursement schedules for hospitals and physicians, additional cost shifting from the already large public program to private employers should be prevented.

—Second, national spending targets should be established. This should help control annual increases by forcing more careful decisions regarding the introduction and over-utilization of technology.

—Third, medical practice protocols and quality measurement systems should be developed to improve the quality of health care and to aid in technology assessment.

—Fourth, medical malpractice reform should be initiated to reduce the incentive for frivolous lawsuits and avoid grossly disproportionate awards.

—Fifth, Medicare must remain the primary payer for the elderly and should be expanded to replace the less efficient Medicaid program.

—Sixth, employers should be encouraged to provide basic health benefits using tax incentives or penalties, thereby extending coverage to all workers.

These recommendations are offered as the basic elements for comprehensive reform of our current system to control medical costs, and to improve the quality of care and access for millions of working Americans. This will also permit our nation

to provide millions of non-working poor and near poor individuals, who are currently not covered by public programs, access to a more efficient health care system.

Recently, The National Leadership Coalition for Health Care Reform which represents a range of companies—including steel, auto, communications, retail, and utility—announced its comprehensive plan. The plan incorporates these six important elements and therefore, AISI supports it. However, AISI is open to other recommendations that would achieve the overall objectives.

Mr. Chairman, we look forward to working with you and other members of the Congress to enact urgently needed comprehensive reform. From the business point of view, no proposal is acceptable that will not control health care costs, assure Americans of the coverage they need, and spread the economic burden of paying for coverage more fairly than the system we have today.

Thank you.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Thank you, Mr. Chairman, I have a few brief remarks. I commend you for holding a hearing on the impact of increased health costs on the economy. I am anxious to hear from the expert panelists that you have assembled here this morning.

Escalating costs in health not only put our health care system at risk, but threaten our economy, commerce and standards of living for U.S. families.

With regard to health care costs, the proportion of spending that the United States devotes to health care has doubled over the past 30 years—from about 6 percent of the gross national product to over 12 percent of the GNP today.

By the year 2000, according to the Department of Health and Human Services, health care spending will climb to over 15 percent of the gross domestic product (GDP).

Unless something is done, we know that federal health spending as a percent of total federal spending is projected by the Office of Management and Budget to grow to nearly one-fifth of total federal outlays in 1996. Before the year 2000, health entitlement programs (Medicare and Medicaid) will surpass Social Security as the single largest component of federal spending.

A recent study by the Steelman Commission indicated that even with strong cost cutting measures in place, health care is predicted to consume 32 percent of gross national product (GNP) by the year 2020.

That means that nearly ⅓ of our economy will be devoted just to health care—and those figures, I might add, just maintain current benefit structures in Medicaid, Medicare and private insurance—they don't add any benefits. For example, if drug benefits were to be added to existing Medicare benefits, these figures would be substantially higher.

Consequently, the resource requirements for health care leave less available funds for the other important national priorities—for example, education, housing, and national infrastructure, or savings.

As we move into the next century our workforce will be changing. There will be more women, minorities, and immigrants assuming responsibilities in the work place. They will need training as they prepare to undertake their tasks. The capacity of our nation to transition into the future rests with having available resources to meet the needs of this new workforce.

We must not overlook the effects of current health care costs as they impact on the lives of individuals. The Steelman Commission makes the following observations:

- Out-of-pocket expenditures will place a growing burden on individuals in 2020. Elderly will be especially affected since their out-of-pocket costs are generally higher than nonelderly.
- Rising expenditures from private insurance will strain the ability of employers and workers to meet the cost of employment-based coverage.
- Projected difference between real wage growth (1.1 percent per year) and real per capita health care cost growth (ranging from 3.1 to 4.3 percent per year) will increase the number of uninsured elderly.

Recognizing that, at current levels of health spending, nearly ⅓ of our economy will be devoted just to health care, this means that every penny of every raise American families receive between now and the year 2020 will go solely to pay for health care costs, if we don't find some way to reduce the health care cost growth rate. Our standards of living will be frozen in time.

Mr. Chairman, these are just a few concerns resulting from the high health care cost growth rate. I look forward to hearing more details this morning about how these increased costs will affect Americans. Thank you.

PREPARED STATEMENT OF WALTER B. MAHER

Chrysler appreciates the opportunity to share with you our views on how the current health system is substantially penalizing U.S. manufacturers engaged in foreign competition, eroding the standard of living of American citizens, and contributing in a major way to the continuing stagnation in the U.S. economy.

As the Congress and the Administration struggle with the issue of health system reform, some issues are admittedly the subject of legitimate debate. On one issue, however, there should be no debate. That concerns the impact of health spending on this nation's economy. Consider, for a moment, if our rate of spending on health care was good for the economy, would the President, his OMB Director, the Speaker and Minority Leader of the House, the Majority and Minority Leaders of the Senate, all 50 Governors, big and small business, organized labor, numerous citizen groups, all be searching for ways to reduce such spending and bring it under control?

So, let the record be clear. The excessive cost of our health system is *bad* for our economy. If it is bad for our economy it is bad for business and it is bad for our citizens. Further, it does not get "less bad" if government can shift its cost to business, thus creating the illusion of having lower taxes. It does not get "less bad" if business shifts costs to employees thus creating the illusion of having lower operating costs. Why? Because citizens have no one to shift their costs to and citizens with less disposable income do not make for a thriving economy. Businesses selling to consumers with no disposable income will not long remain in business.

Thus, we commend you, Mr. Chairman, for addressing this issue in the way you have: specifically, addressing the impact of health costs on our economy as a whole.

HARMFUL IMPACT ON U.S. MANUFACTURERS

Starting with a sub-set of the economy, let us examine the impact health related expenses have on manufacturers, in general, and the auto industry in particular:

- If health costs were evenly distributed throughout the economy, a U.S. business competing with a Japanese firm would start out with a 131% health cost penalty (Exhibit 1).
- Pile on cost shifting from the government, and the penalty compared with foreign firms gets worse. For example, Medicaid covers only 40% of the poor, and even for those it covers it pays doctors and hospitals far less than their costs. Medicare and other government payers also pay below cost (Exhibit 2).
- Pile on cost shifting from the private sector, and the penalty compared with foreign firms gets worse yet. Example: ¾ of the uninsured have jobs or are dependents of people with jobs. Rather than spreading health costs through retail and service firms, which have little or no foreign competition, we shift costs to manufacturers, who do face brutal foreign competition, because they are the firms who most often do offer health benefits, and whose employees frequently have spouses or dependents employed in the retail and service sectors. A recent report on Employer Cost Shifting Expenditures prepared for the National Association of Manufacturers by Lewin/ICF revealed that 28% of U.S. manufacturers' health costs were accounted for by cost shifting from government and other employers (Exhibit 3).
- Adding insult to injury, the U.S. health system penalizes a business for its longevity. The older your workforce, the more retirees you have, the higher your costs. Example: If Chrysler built a plant in France, Germany or Japan, and paid its workers the same wages as established French, German or Japanese manufacturers did, its health costs would be substantially similar (and identical in France) to those of its competitors, even though the Chrysler workforce would undoubtedly be younger, with no retirees. Why: because in those countries business pays for health care on a payroll tax basis. Conversely, when foreign firms come to our country and open plants, they can offer comparable wage and benefit programs, but enjoy a significant health cost advantage, simply because of employee demographics. They employ a workforce many years younger, and are a generation away from beginning to accumulate numbers of retirees. That gives them a major cost advantage they have not earned; it is simply a product of our health care system.

This assault on the manufacturing sector has had a particularly harmful impact on the auto industry. According to a recent study by the University of Michigan's

Transportation Research Institute, health care represents almost $1,100 of the cost of every Big Three product, sharply higher than the comparable costs of a Japanese manufacturer (Exhibits 4 & 5). Further the *difference* between Chrysler's spending for health this year and a Japanese firm will well exceed $500 per car. Putting that in perspective, Chrysler's *total profits* have exceeded $500 per car only 4 times this century!

In testimony earlier this year before the Subcommittee on Commerce, Consumer Protection, and Competitiveness of the House Committee on Energy and Commerce, David J. Andrea of the University of Michigan's Transportation Research Institute expressed the following concern regarding the auto industry:

> "Cost reduction programs are at the core of each Big Three manufacturer's competitive improvement effort . . . . The industry must address costs under its control and governmental action must address industry competitiveness factors under public policy control . . . . Health care cost reform is one public policy issue that must be addressed r the domestic Big Three to fully regain international competitiveness."

Regrettably, however, this public policy issue has not been addressed. As such, the absence of any semblance of a national health policy for this country has harmed this country economically and has impeded the international competitiveness of businesses offering health benefits.

WHAT BUSINESS CAN DO

The private sector has been hard at work on the health cost problem for years. Businesses, however, are finding there are clear limits to what they alone can do in response to this problem, other than managing their benefit programs as effectively as possible. Simply put: the best managed health care plan remains exposed to the type of cost shifting described above.

Accordingly, employers, the second largest payer, in addition to utilizing managed care programs, have found they are also able to do what the public sector is perfecting, namely shift costs. Consider for a moment that an employer, who wishes to remain an employer, must recover its costs. Accordingly, to get relief from health costs employers can:

- Add to consumer prices to the extent the market permits.
- Reduce the rate of wage growth to the extent the labor market permits.
- Increase deductibles and copayments or reduce benefits to the extent the labor market permits.
- Hire fewer people.
- Locate jobs off-shore.

They can also:

- Earn less profits.
- Pay less taxes, which reduces funds available for other societal needs.
- Pay less dividends.
- Have reduced capacity to invest in R&D, training, etc.

All of this impacts individual citizens. It is clearly contributing to the growing awareness among Americans that it is they who ultimately bear the brunt of a health system without fiscal discipline. As noted earlier, a citizenry squeezed for disposable income coupled with a weakened business community do not make for a vibrant economy. And, completing the vicious cycle, a sound American economy is vitally important for those American businesses who wish to succeed in a global marketplace.

Quite clearly, therefore, if American manufacturers in general, and American auto manufacturers in particular, are to be a force in the world economy in the 21st Century, action by Congress and the President is required to rectify these competitive penalties and to restore vigor to the American economy.

Our objectives should be a health system within which the necessary health care needs of all citizens are met; a system which consumes resources prudently, balances spending on health with other national priorities, spreads costs over the broadest possible base and does not disproportionately impact any segment of the economy; and a system which exists in a context of continuous quality improvement.

To accomplish these objectives certain principles are key:

EQUITY AMONG PAYERS

This obviously is only an issue were we to have something other than a single-payer system. Clearly, public coverage must be available for all the poor. Further,

if the private sector is to have the government as a "partner," this requires a process for the determination of fair provider fees for fee-for-services medicine, with such fees applicable to all public and private sector payers. There should be no room for cost shifting from the public to the private sector other than through the valid process of appropriating tax revenues to fund public programs.

EQUITY WITHIN THE ECONOMY

If we are to rely on employer financing in the future, all employers must participate. This can be done without harming weak or deterring start-up enterprises and without encumbering established employers with unreasonable costs.

FISCAL INTEGRITY

No nation on earth has embarked on a program to provide all citizens access to health care without concurrently adopting a strategy to control aggregate national health care spending. The central lesson of our experience with health care, and health care reform, over the past twenty years is that in the absence of system-wide constraints, costs get shifted. It is easier to shift costs than to control them—and we have learned that if they *can* be shifted, they *will* be. Piecemeal attempts to tamp down costs are illusory; savings in some sectors or for some consumers of health care services just get offset by increased costs elsewhere.

Further, the way costs get shifted is most unfair. Consider the difference between how taxes are levied and how health costs are shifted. Taxes are usually levied in a way to spread the cost of meeting various societal needs across a very broad tax base. Further, other than consumption type taxes, taxpayers usually do Rot have the luxury of opting not to pay a tax. The U.S. health system, however, through the many opportunities it presents to shift costs, in effect levies a tax which is applicable only to private sector health care bill payers. If you want to avoid "the tax," all you have to do is to cease being a bill payer. As is noted earlier in this testimony, for manufacturers the "tax rate" is now 28%. As more and more businesses drop coverage, as Medicare and Medicaid continue their cost shifting, the "tax rate" goes up. Worse yet, this outrageous "tax" is not even spread fairly among the private sector bill payers getting stuck. Is this "tax" based on ability to pay? Is it based on how large the business is? Is it based on the size of the employer's payroll? No. It is based on the size of the employer's health care bill. In other words, it is based on how old the workers are, how sick they are, how many children they have, and how many retirees the employer has. In short, it is extraordinarily punitive to mature American firms and creates a most unfair competitive disadvantage which no foreign enterprise faces.

COST OF INACTION

Americans are clearly not yet fully aware of the growing costs they continue to bear as a result of the failure to step up to the need to reform our nation's health care system. Barring change, we believe health costs will reach $1.4 trillion by the year 1997 and absorb over 17% of our nation's GDP (Exhibit 6). Health costs are growing far faster than family income, than business income, than local, state or federal government income (i.e., tax receipts). The result: a steady reduction in citizens' standard of living as health care absorbs more and more of our citizens' and our nation's resources and saps the strength of its businesses. Indeed, as health spending remains unchecked, spending for all other societal needs is effectively being rationed.

The businesses of America, particularly our manufacturing base, need health system reform now. The citizens of America need health system reform now to help them regain the standard of living they have seen erode over the past decade. We need to take the hundreds of billions of dollars our health system wastes each year and make it available for redeployment in our economy, investing to educate children, to enhance the skills of our workers, to improve our infrastructure, and to make our domestic industries more efficient. In short, to help meet the needs of all citizens and our economy in general. We must bring our country's health costs much more in line with our major trading partners or continue to pay the price of a loss of jobs and a declining standard of living.

Per Capita Health Spending in Selected Countries, 1990

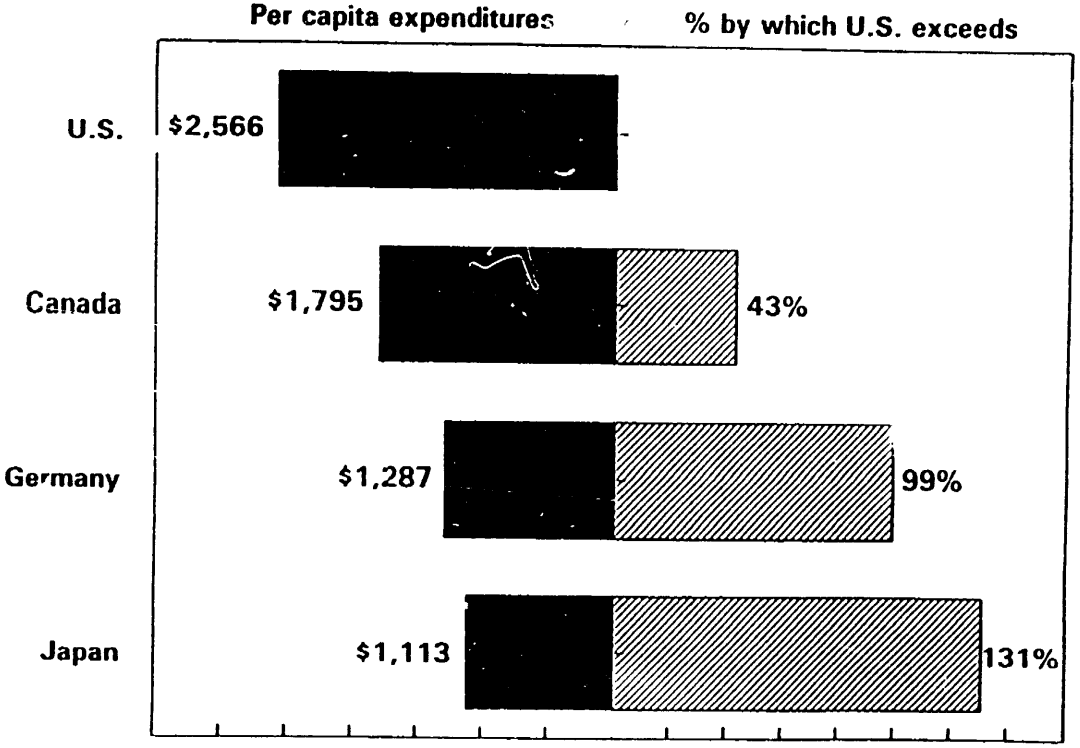
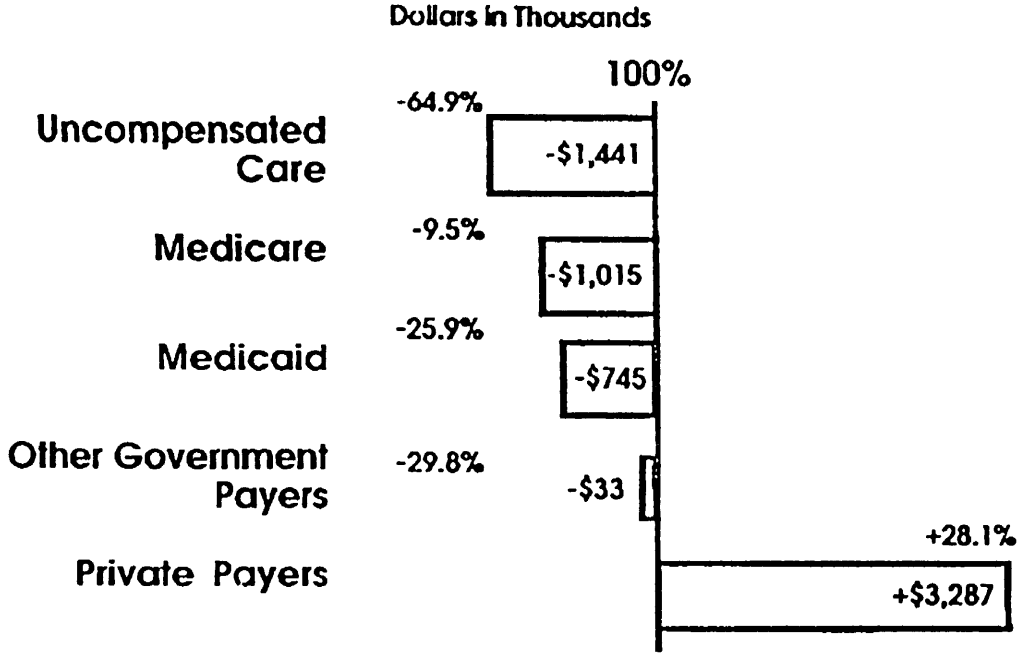


Exhibit 1

Average Payments of Payer Groups in Relation to Costs



Source: ProPAC analysis of American Hospital Association 1989 Annual Survey.

Exhibit 2

Exhibit 3

COST SHIFTING IN 1991

($ BILLIONS)

MANUFACTURING INDUSTRY HEALTH COSTS	$41.3
- WORKING DEPENDENT COVERAGE	$ 6.4
- UNINSURED WORKERS	0.8
- UNINSURED NON-WORKERS	1.6
- PUBLIC PROGRAM UNDERCOMPENSATED CARE	2.7
	$11.5

28% OF MANUFACTURING INDUSTRY HEALTH COSTS REPRESENT COSTS SHIFTED FROM OTHERS

SOURCE: Employer Cost-Shifting Expenditures, prepared for the National Association of Manufacturers by Lewin/ICF, September 1991

Exhibit 4

UNIVERSITY OF MICHIGAN ESTIMATES
BIG 3 US/CANADA
HEALTH CARE COST PER UNIT
1990

DIRECT COSTS	$ 652
SUPPLIER COSTS	$ 434
TOTAL	$1086

Exhibit 5

UNIVERSITY OF MICHIGAN ESTIMATES
HEALTH CARE COST PER UNIT
BIG 3 US/CANADA vs JAPAN

DIRECT COSTS ONLY

	1988	1990
US/CANADA	$500	$652
JAPAN[1]	$220	$240

[1]From Sanford C. Bernstein & Company, Inc.

HEALTH CARE COSTS

- ABSORBING A GROWING SHARE OF U.S. RESOURCES -

($ Billions)

YEAR	GDP[1]	HEALTH SPENDING[2]	% GDP	% OF GDP GROWTH ALLOCATED TO NEW HEALTH SPENDING
1991	$5,675	$ 738	13.0%	
1992	$5,926	$ 817	13.8%	31%
1993	$6,307	$ 909	14.4%	24%
1994	$6,712	$1,012	15.1%	25%
1995	$7,141	$1,126	15.8%	27%
1996	$7,589	$1,254	16.5%	29%
1997	$8,054	$1,395	17.3%	30%

[1]As reported and estimated in Budget of the United States Government, Fiscal Year 1993, as submitted by President Bush, January 29, 1992

[2]Growth rate as estimated by Economic and Social Research Institute, October 1991

Exhibit 6

PREPARED STATEMENT OF DONALD W. MORAN

Mr. Chairman: I am Donald W. Moran, Senior Vice President of Lewin-ICF, a Washington-based health policy research and consulting firm. It is a pleasure to appear before the Subcommittee this morning to discuss issues affecting the cost of employer-based health insurance.

My prepared remarks this morning are based on the results of research Lewin-ICF conducted on behalf of the National Association of Manufacturers, which engaged our firm to conduct research into the phenomenon commonly known as "cost-shifting." While we at Lewin-ICF are grateful for NAM's support of this research, I do not appear as a representative of that (or any other) organization this morning, and my remarks should not be construed as an attempt to characterize that organization's views, or my firm's, on any issue.

COST SHIFTING DEFINED

As commonly used in the health policy debate, the term "cost shifting" is defined to mean the extent to which different payers of health care costs in our system may be required to pay prices for health care goods and services that are systematically different from the actual cost of the care provided. The gist of the argument is that if certain classes of payers use their power in the marketplace to compel health care providers to accept reimbursement at less than the full cost of care for those payers' patients, providers must of necessity charge other patients *more* than the full cost of care received in order to recover their costs of doing business. In the Federal policy context, the most common contention is that Federal reimbursement programs (primarily Medicare, Medicaid and CHAMPUS) have reduced their payment levels relative to cost to a point where providers are compelled to raise prices to private payers, who are predominantly covered by private employer-based insurance, above the true cost of treating those patients. In attempting to analyze this phenomenon, Mr. Chairman, it is important to note that the nature and magnitude of the effects will vary substantially depending the accounting viewpoint adopted to measure the "true" cost of care to different classes of patients. Typically, the accounting systems employed by health care providers do not attempt to capture costs at a sufficiently-detailed level to permit direct allocation of costs to patients of different types. In the case of physicians' professional services, comprehensive data are sparse, and physician office accounting systems are not typically designed to capture costs at the patient level at all. Most analysts of the cost-shifting phenomenon, therefore, are compelled to look primarily at the hospital sector, where the need to collect and report accounting data by payer class has long been prevalent, due to the requirements of the cost-based hospital reimbursement systems that were the prevailing mode of payment in the decades preceding the adoption of the Medicare prospective payment system.

Even in the hospital setting, however, it is important to note that allocations of costs among payers require simplifying assumptions. The most commonly-employed assumption is that the relationship between cost incurred and charges ultimate billed to individual patients is stable across patient classes within distinct clinical departments. For both economic and clinical reasons, Mr. Chairman, this is a fairly strong assumption. Nonetheless, in order to be able to explore these effects at all, it is necessary to adopt this assumption in order to make use of the only cost accounting data that are available.

INTER-PAYER COST SHIFTING

In the table on the next page, Mr. Chairman, I present our estimates of the extent to which reimbursements hospitals receive on behalf of distinct classes of patients vary from the cost of care provided (as I have just defined cost). As that table suggests, we estimate that total reimbursements to hospitals for the major categories of non-private patients fell short of accounting costs by $21.5 billion in 1991. That amount, we estimate, is roughly equally divided between an estimated $10.8 billion shortfall due to uncompensated care, and the estimated $10.7 billion difference between reimbursement and allocated accounting costs from the three major Federal/State reimbursement programs. Of the reimbursement shortfalls among public payers, we estimate that $8.4 billion, or 78%, was due to shortfalls in Medicaid. While Medicare shortfalls are substantially smaller, it is important to note that, in the mid-1980's, Medicare reimbursements typically exceeded accounting costs by as much as $4–5 billion annually. Hence, the decline in Medicare profit margins over the last seven years has created substantial and growing pressures to seek elsewhere for revenues.

REIMBURSEMENT SHORTFALLS FROM NON-PRIVATE PATIENTS, 1991

[In billions of dollars]

UNCOMPENSATED CARE	$10.8
PAYER REIMBURSEMENT SHORTFALLS:	
Medicaid	8.4
Medicare	2.2
CHAMPUS	0.1
	10.7
TOTAL HOSPITAL SHORTFALL	21.7
TOTAL EMPLOYER HEALTH COSTS	171.1
HOSPITAL SHIFT AS A PERCENT	12.6%

How much of these cost shortfalls have actually been "shifted" to employer-based health insurance? The answer to that question is complex. Yet to the extent that hospitals, on average, are recovering their full cost of care from current revenues, or from funds that must be diverted from elsewhere, it is probably reasonable to assume that essentially all of these costs find their way into amounts paid by private payers in hospitals.

It is important to note that, compared to the total health care bill currently being paid by employers, this $21.5 billion shortfall is consequential. Since we estimate that employers paid $171.1 billion to finance employer-based health insurance plans in 1991, the reimbursement shortfall represents 12.6% of total employer health spending.

INTER-EMPLOYER COST SHIFTING

It is clear, Mr. Chairman, that reimbursement differentials among payers—and the costs of treating those unrepresented by any payer at all—are a significant cost in the employer-financed segment of our health care system. There is, however, another form of "cost-shifting" that is less well understood that has an equally significant impact on employer costs.

This "inter-employer cost shift," Mr. Chairman, is due to the significant number of dual-income households in the United States. In many cases, both spouses are employed in jobs that offer health insurance. Unless the health insurance provided on both jobs is totally free to the employee for their own coverage and that of their dependents, dual-income households commonly elect to enroll the family in one plan or another. Not surprisingly, these families tend to make the choice among the alternatives that gives the household the best benefits at the least cost.

In addition to these dual-choice households, a significant number of two-worker households are offered insurance by only one of the employers. In that event, of course, the family typically elects to enroll the spouse that does not receive insurance on the job as a dependent on the health plan of the employer that does offer coverage.

While the availability of these choices has a positive impact on the availability of insurance for many Americans, the result of these choices amounts to a "cost shift" to the employer whose coverage is chosen. For a significant number of the individuals covered under employer-sponsored health plans as dependents are actually employed somewhere else. We estimate that, in 1991, 17.3 million adult workers in the United States were covered as dependents on a health plan sponsored by someone other than their own employer. We estimate the costs of covering these individuals at $26.4 billion—an amount equal to 20% of all employer costs of providing coverage.

If the consequences of these decisions were randomly spread out around the economy, of course, these costs might be expected to net out, since a firm covering some dependent workers might find some of its own employees electing coverage elsewhere. Since employees almost always choose to their financial advantage, however, employers who offer relatively more generous benefit packages a far more likely to attract working dependents than they are to shed them. Due to this reason, as I will illustrate, the incidence of this "inter-employer cost shift" is highly concentrated in a few industries.

My second table, which is extracted from our report to the NAM and appears as "Table 8," presents a summary of how this "inter-employer cost shift" interacts with the "inter-payer cost shift" to produce widely divergent effects on employers of dif-

ferent sizes, and in different industries. While a lot can be learned by close examination of this table, I will briefly summarize what I personally believe to be the highlights:

- First, the value of the coverage provided to workers in small firms by plan sponsors in larger firms outweighs, by a factor of more than eight times, the costs borne by small employers due to inter-payer cost shifts.
- Second, the largest employers, due to the heavy concentration of working dependents in their health plans, bear costs that are greater than the entire amount of cost shifting borne by employer-based health plans as a whole.
- Third, when viewed from the perspective of individual industries, two sectors of private industry—manufacturing and transportation—together bear 88% of the effects of all cost shifts in the system. Manufacturing industries alone cover 25% of all dependents employed elsewhere. The services and trade sectors, by contrast, are substantial net beneficiaries, due to the heavy offsetting effect of the inter-employer cost shift.
- Fourth, from the standpoint of public policy, it is also important to observe that government employee health benefit programs, at all levels, bear significant costs due to coverage of dependents employed elsewhere.

In all, when the cost shifting phenomenon is viewed from the perspective of inter-employer cross-subsidies, we gain substantial insights into the concerns expressed by sponsors of employment-based health plans regarding the problems they face. I hope you, and other Members of this Subcommittee, find these data to be helpful in assessing the choices before you. If additional information on this subject would be of value to you, I would be happy to share with your staff other results from our work in this area.

Thank you for the opportunity to appear this morning.

TABLE 8

NET COST SHIFTING AMONG EMPLOYERS IN 1991
(In Billions) [a]

	NET INTEREMPLOYER COST SHIFT DUE TO			OTHER COST SHIFTING		
	Working Dependent Coverage	Unsponsored Care for Uninsured Workers	Total Interemployer Cost Shift	Unsponsored Care Cost Shift for Nonworkers	Public Program Undercompensated Care Cost Shift	Total Net Cost Shift
Firm Size						
1-24	-$12.6	-$1.6	-$14.2	$1.0	$1.7	-$11.5
25-99	-0.4	-0.1	-0.5	0.7	1.2	1.4
100-499	1.8	0.3	2.1	1.1	1.8	5.0
500-999	0.9	0.1	1.0	0.4	0.6	2.0
1,000 or More	10.3	1.3	11.6	3.3	5.4	20.3
Industry						
Transportation	1.7	0.2	1.9	0.6	1.1	3.6
Construction	-0.2	-0.1	-0.3	0.2	0.3	0.2
Manufacturing	6.4	0.8	7.2	1.6	2.7	11.5
Trade	-4.9	-0.8	-5.7	0.9	1.4	-3.4
Services	-7.5	-0.4	-7.9	0.9	1.5	-5.5
Finance	-0.3	0.1	-0.2	0.4	0.6	0.8
Federal Gov.	1.1	0.1	1.2	0.2	0.3	1.7
State/Local Gov.	1.8	0.5	2.3	1.1	1.8	5.2
Other	1.9	-0.4	1.5	0.6	1.0	3.1
All Firms	$ 0.0	$0.0	$ 0.0	$6.5	$10.7	$17.2

a A negative value indicates a net subsidy for that industry/firm size group. A positive value indicates a net subsidy payment to other industry/firm size groups.

SOURCE: Lewin-ICF estimates using the Health Benefits Simulation Model (HBSM).

PREPARED STATEMENT OF JOHN J. SWEENEY

Good morning. I am John Sweeney, President of the Service Employees International Union (SEIU). We represent over one million members who are employed as janitors, nurse aides, clerical workers, and other service workers. I am also the Chairman of the AFL-CIO's Healthcare Committee.

Mr. Chairman, I welcome the opportunity to present to you and the other members of this committee the workers' perspective on the healthcare crisis confronting our nation.

In all the years I've been with the labor movement, I've never seen a bargaining issue more difficult than health care is today, nor witnessed such anxiety among workers over their benefits.

Each time we sit down to bargain a new contract, it becomes increasingly clear that health costs have gotten too far out of control for us to solve this crisis at the bargaining table.

We already have 37 million uninsured Americans and another 50 million who are underinsured. These appalling statistics are bound to worsen as more and more middle class families are finding basic health coverage slipping beyond their reach.

Despite the recent emphasis on cost containment strategies, healthcare costs have continued to rise at exponential rates, with employer costs running two to four times general inflation.

As a result, well-meaning employers and unions are reaching bargaining stalemates over the issue of who will pay the ever-growing health insurance bills. All too often, union members are left with a choice between cutbacks in their health coverage or foregoing any wage increase.

Not surprisingly, health benefits have now become a major issue in 78 percent of all strike activity.

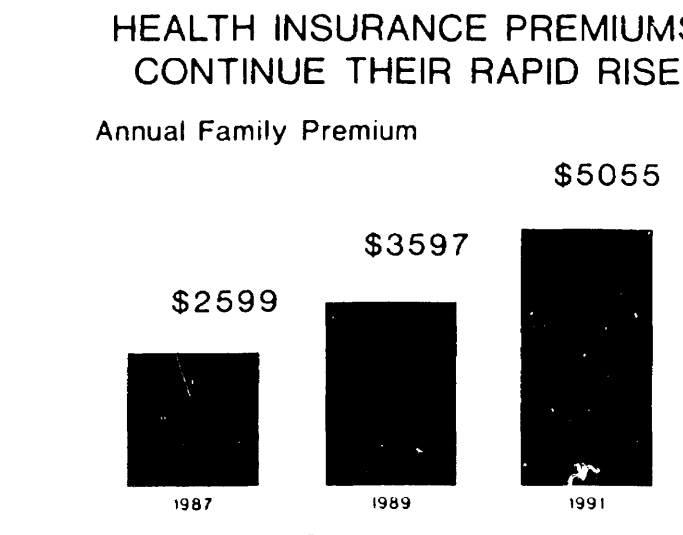
That number is sure to grow, for we are told that by the turn of the century, the cost of insuring one employee for one year will reach between $20,000 and $22,000.

The urgency of our healthcare problems demands that we enact national health reform legislation for working Americans now.

As horrendous as the situation is for the 37 million people who have been without health coverage for some time, our members believe that they are just one insurance premium increase, or one serious illness away from the same fate.

And they have every reason to be concerned.

Let me share with you the results of a recent survey of health plans that cover SEIU members in both public and private sector employment.



Source SEIU Public Policy Department

It shows that premiums for family coverage have nearly doubled in just four years—from $2,600 in 1987 to $5,000 in 1991.

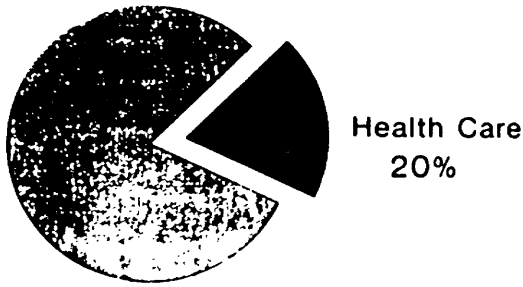
This is money that could have gone into the family budget. That 100 percent increase in employer costs is equivalent to a 10 percent wage increase that our members will never see.

Aside from the foregone wages, our workers have had to pick up a larger share of the premium as well. Over this four year period, the employee contribution towards the total premium increased nearly 200 percent—double the increase for employers.

And of course, premium payments represent only a part of a worker's total healthcare bill. Workers also have to meet their deductibles, as well as foot the bill for co-payments on physicians visits, prescription drugs, and hospital stays. Taken together, these represent a worker's maximum out-of-pocket liability for healthcare costs.

The SEIU survey showed that the average maximum out-of-pocket liability of our members rose by almost fifty percent in the past two years.

HEALTH COSTS ARE CONSUMING A GROWING SHARE OF AFTER-TAX INCOME



Maximum Family Plan Costs as % of Income

Source: SEIU Public Policy Department

This means that even though they have insurance, lower-wage workers could spend up to 20 percent of their after-tax income on health care.

We also found that employers have begun placing greater emphasis on managed care plans as a way to control costs. But the SEIU survey results indicate that HMO plans are by no means a cure-all for the healthcare cost crisis.

Particularly over the past two years, HMO premiums have been rising at about the same—or even higher rate—than indemnity and PPO plans.

Every way we look at it, the outcome is the same. Healthcare costs have now become an important factor in the steady erosion of middle class living standards.

Here are few specific examples from various SEIU locals across the country.

In Michigan, SEIU Local 31 M represents workers employed by the State Employment Services Commission. In 1987, annual premiums for our members covered under the State Plan amounted to $3,700 for family coverage. By 1991, these premiums had jumped to over $7,200. To try to combat these huge cost increases, our SEIU locals in Michigan have formed a task force with the Governor's office to study healthcare reform options.

In Minnesota, SEIU Local 113 represents nursing assistants, janitors, and dietary aides at Methodist Hospital who earn between $7.63 and $9.77 an hour. Although Methodist Hospital self-insures, it charges these workers at least $157 per month for family coverage (and as much as $271 for a plan with lower deductibles and copayments). Total premiums, including the employer share, total up to $408 a month, per worker. Today, the health premium bill for a worker at Methodist Hospital amounts to half his wages.

Other SEIU Locals have similar stories. In Georgia, our state employee members received a 2.3 percent salary increase, but higher healthcare premiums swallowed up that increase and more. In Oregon, healthcare premiums have risen over 13 percent at Good Samaritan Hospital to $323 a month and the administrators are talking about layoffs and staff reductions. In Washington State, our Local would like to negotiate dependent coverage for all workers at Valley Medical Center, but last year the premiums for dependent coverage went up 40 percent, pricing them out of reach.

This drain on living standards began before the current recession and will continue well after the economy recovers—unless we act.

The Commerce Department estimates that our total healthcare spending will be $817 billion in 1992—rising at the rate of 12 to 13 percent annually.

We just can't sustain these increases much longer.

Wages aren't rising at 12 to 13 percent.

State and local tax revenues aren't rising at 12 to 13 percent.

Spending on education isn't rising at 12 to 13 percent.

From the family budget to the federal budget, the pressure of health costs is reordering our priorities, without our consent.

The record is clear that voluntary cost containment measures simply won't do the job.

Individually, companies and unions have done what they can to control and manage health costs.

But it hasn't been enough to protect either the living standards of workers or the bottom lines of businesses.

A dozen states have now tried a coordinated, voluntary strategy for holding down costs and extending access to care through the use of tax credits and low-cost plans.

Minuscule gains in coverage have been swamped by the rising tide of uninsured and exploding costs.

We must be realistic about incremental reform. A decade of incremental steps has not moved us closer to a resolution of the healthcare crisis.

In particular, insurance reforms cannot make health insurance accessible and affordable unless they are enacted as part of a comprehensive reform effort that controls costs and guarantees coverage. If changes to the small group insurance market—similar to those in S. 1872—are enacted without cost containment, three small groups will see their rates go up for each group that receives any reduction. Many of the small groups will experience increase of 10 to 20 percent.

Unquestionably, it would be more beneficial to the small group purchasing community, as well as all others in the health care system, that nothing be done rather than subject an already ailing market to the effects of such ill conceived and harmful legislation.

Again, incremental policy changes make sense only as building blocks in a comprehensive strategy.

And we can't hope to solve the problem city by city or state by state.

That's why our members, and the members of other unions, are pressing for national action on comprehensive health reform in 1992.

Thank you.

COMMUNICATIONS

STATEMENT OF DAVID J. ANDREA*

THE IMPORTANCE OF A COMPETITIVE DOMESTIC AUTOMOTIVE INDUSTRY

The U.S. motor vehicle industry is the largest manufacturing industry in the United States. Employing an estimated 1.1 million persons[1] (1990) the industry shipped $226.1 billion of output (shipments of motor vehicles and parts).[2] There are approximately 3,000 automotive suppliers (using the most specific definition of motor vehicle parts and accessories and automotive stampings)[3] and an additional 25,000 to 30,000 companies involved to some extent in automotive production.

From the perspective of employment (national income, standard of living, consumer confidence, and tax revenue), production shipments (gross domestic product, cross-industry purchases), and other factors such as applied R&D advances and materials and manufacturing processes development, a competitive domestic automotive industry is the single most important driver of our U.S. manufacturing economy and supports a significant amount of construction and service activity as well.

COMPETITIVENESS

Automotive competitiveness is a complex web of factors. A recent project by our Office identified many important success factors through the year 2000 including: product quality, effective utilization of human resources, total production cost, manufacturing cost, and effective integration of supplier efforts.

Market success—the ability to increase market share—is the sum total of each of these factors individually and the interaction between them.

Three common elements run through each of these success factors: human resource skills, cost/capital allocation, and time. Industry controls the quality and resource levels of human skills, cost/capital allocation, and time targeted at each success factor.

But public policy and government action dictate the allocation of each of these elements across the range of success factors. Therefore, it is possible for the industry to reduce manufacturing costs to the most efficient level possible yet still be noncompetitive on total production cost because of tax policies, regulatory timing, or health care expenses.

REQUIRED INDUSTRY EXPENDITURES

The industry has consistently invested over $10 billion on new plants and equipment since 1984 even though profits have been declining to the point where the industry operated in a deficit for 1989, 1990, and 1991. The industry must maintain this investment level—if not higher—to keep a continuous flow of new products into the show rooms. There will not be one three-month period over the next five years that will not have a new vehicle or powertrain introduction by a Big Three or Japanese manufacturer.

The domestic Big Three have lost over twelve percentage points in market share over the last twelve years. We are concerned that if the domestic industry loses any more market share, additional radical restructuring and reduction of the industry

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*Senior Research Associate, Office for the Study of Automotive Transportation, University of Michigan Transportation Research Institute.

[1] Sean P. McAlinden, "The Effect of U.S.-Japan Automotive Trade on the U.S. Automotive Parts and Components Industry," Testimony before the United States Senate Committee on Banking, Housing, and Urban Affairs, Dearborn, Michigan, December 2, 1991.

[2] *Survey of Current Business*, Bureau of Economic Analysis, United States Department of Commerce, September 1991, p. S-4.

[3] McAlinden, Senate Testimony.

will need to occur—far beyond what we have experienced to date. It is imperative that the industry recover its profitability so that product development and other investment strategies may remain on target.

In addition to these market demands, the industry must keep pace with fuel economy, emission, and safety regulatory standards as well. Never before has the industry faced such a multi-faceted and rigorous regulatory front.

It may be said that all companies face the same dilemma, which is correct. It is this very point that makes corporate costs in the control of public policy so critical and a differentiator in international competitiveness. Vehicles sourced internationally are priced to the selling market conditions, but value, quality, freshness of design, and other consumer decision criteria are determined based on a company's costs and profit margins in the country origin. Therefore, the U.S. auto industry must be competitive vis-a-vis world competitors in solving issues such as emission controls, and the public policy governing the U.S. auto industry must be competitive vis-a-vis other countrys' public policy.

U.S. AUTOMOTIVE INDUSTRY COMPETITIVENESS AND ONE PUBLIC POLICY ISSUE: HEALTH CARE

Just as the automotive industry can not improve only one area (quality, dealerships, labor, management, etc.) and claim to regain competitiveness, we can not only address health care and pretend our competitiveness will improve. Other public policies such as taxation, financial markets, product regulation, and judicial systems must evolve as well to international standards. We do believe that the health care system is the major public policy issue impeding the domestic automotive industry's competitiveness.

Based on recent work performed at OSAT, (Office for the Study of Automotive Transportation), we estimate that the average 1990 health care component of a North American Big Three-produced vehicle was $1,086. This expenditure includes U.S. and Canadian Big Three health care provided benefits, as well as Medicare payroll costs, worker's compensation health care portion costs, and short-term disability and sick leave costs. The figure also includes our estimate of supplier-contributed health care expenditures. Between 1985 and 1990, health care cost per unit has escalated 12.4% per year. Because costs rose and production fell, the Big Three average health care cost per unit would be even higher per unit in 1991 than our 1990 estimate.

This health care cost figure is equivalent to a typical four-cylinder engine and manual transmission in a compact vehicle. Referring to an earlier point: value, quality, freshness of design, and other consumer decision criteria are determined based on a company's costs and profit margins in the country of origin. While a customer can see, feel, and hear an engine or transmission, he or she is very unlikely to judge one car superior to another because of its producer's health care content. Therefore, the U.S. manufacturers are at a disadvantage vis-a-vis their foreign (and even foreign-owned, U.S.-based competition.

We have not secured adequate foreign data to perform a thorough analysis of Japanese or European health care costs. However, using the information we have secured, in addition to well-informed assumptions, we estimate 1990 Japanese vehicle health care costs to be $550 for vehicles produced in Japan, and approximately $475 for vehicles produced in the United States. Therefore, we would agree with others that there is at least a $500 differential in health care costs per vehicle between U.S. and Japanese manufacturers. Based on the 9.6 million vehicles the Big Three produced in North America in 1990, a $500 cost differential equates to $4.8 billion of spending allocated into health care and away from investment in the industry's people, product, and plant.

One way to visualize the impact of medical costs versus other input costs and the final cost of the product is to compare the intermediate producer price index (a good measure for automotive component inputs) and the general consumer price index (a measure of wage and salary increases). Intermediate producer prices have risen 14.5% over the last 8 years and the general consumer price index has risen 31%. Much more dramatic is the rise in the health care index, increasing approximately 63%. The price index for new vehicles, in the same period, rose 21%. This shows that car prices have eased upward reflecting overall inflation and increases in manufactured goods. However, the one cost element that is squeezing profit margins and re-allocating resources is medical care. This is why many vehicle manufacturers and suppliers are asking for health care cost reform.

One major structural element of the U.S. traditional domestic industry that must be considered in any health care reform is the ratio of actives to retirees. Due to the age of the U.S. auto industry—more a function of history and less of manage-

ment—the number of retirees comprises 44% (1990) of the total number of Big Three insurance contracts. If the five-year retiree growth rate continues, the Big Three will have more retirees than active employees within five years. This is a structural issue that the Japanese in Japan are only beginning to feel and is years away for the transplant operations in the United States. The Big Three are completely accountable for this pool—it is a "fixed cost" that can only rise at a rate faster than the overall medical care inflation rate because of the number being added to this pool through the downsizing of the industry and the naturally increased health care costs associated with an aging group of humans. This single structural factor will always result in higher Big Three health care costs compared to other systems having different financing schemes.

Health care cost reform is one public policy issue that must be addressed for the domestic Big Three to fully regain international competitiveness. It is imperative the industry regain its competitiveness because there is no other industry or governmental agency that is prepared to provide the employment, income, and social fabric support generated by the traditional domestic automotive industry.

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