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COMPREHENSIVE HEALTH CARE REFORM AND COST CONTAINMENT

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

ON

S. 1177, S. 1227, S. 1872, S. 2077 S. 2114, S. 2320, S. 2346, and S. 2513

JUNE 9, 17, AND 18, 1992

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COMPREHENSIVE HEALTH CARE REFORM AND COST CONTAINMENT

TUESDAY, JUNE 9, 1992

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

The hearing was convened, pursuant to notice, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Baucus, Mitchell, Riegle, Rockefeller, Daschle, Breaux, Packwood, Chafee, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H–27, May 18, 1992]

BENTSEN PLANS CLOSER LOOK AT COMPREHENSIVE HEALTH CARE REFORM, JUNE HEARINGS WILL FOCUS ON SPECIFIC APPROACHES

WASHINGTON, DC—Senator Lloyd Bentsen, Chairman of the Senate Finance Committee, Monday announced three additional hearings in an examination of comprehensive health care reform proposals.

The hearings will be *Tuesday, June 9, Wednesday, June 17, and Thursday, June 18, 1992 in Room SD-215 of the Dirksen Senate Office Building. The hearings will begin at 9:30 a.m.*

"Americans want comprehensive reform of our health care system, and we must do that as quickly as possible. But while the need for reform is clear, arriving at a legislative remedy will be neither simple nor easily accomplished," Bentsen said.

"I called a series of hearings, which began this month, to take a close, careful look at the wide range of approaches to comprehensive reform. In June, the Finance Committee will hold additional hearings to examine specific approaches for comprehensive reform in more detail," Bentsen said.

"On June 9 the Committee will focus on proposals for expanding employment-based health insurance coverage. The June 17 hearing will center on proposals for instituting universal coverage through public health insurance programs. And on June 18 we will examine proposals for tax-incentive based health care reform," Bentsen said.

"Americans need assurance that they will have affordable health care when they need it most, and I expect these hearings to help us in our efforts to reform our health care system."

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

The CHAIRMAN. If you would please cease conversation and take seats, the hearing will get under way. In the Senate and in the House we know we have the best health care that is available in the world for those people that can afford it. And while we agree that the system is broken and needs very major reform, we have not been able to achieve a consensus yet on how to accomplish it.

So, today the Finance Committee continues to consider those proposals; proposals for comprehensive reform of the health care system.

Today, we will be discussing those proposals that would expand access to employment-based health insurance. In hearings on June 17th and 18th, we will examine the other approaches to health care reform.

Of particular interest this morning are three bills that have been referred to the Finance Committee. Senator Rockefeller introduced the Pepper Commission recommendations as S. 1177.

S. 1227, the HealthAmerica Act, was introduced by Senators Mitchell, Kennedy, Riegle and Rockefeller. And Senator Packwood introduced S. 2114, the Comprehensive Health Insurance Plan of 1991.

These bills offer thoughtful strategies to improve access to health insurance and slow growth in health care costs. About 140 million Americans are covered under employment-related health insurance plans.

Proponents of employer mandates or play-or-pay approaches seek to build on this foundation while providing universal health insurance coverage and controlling growth in health care costs.

On the other hand, questions have been raised about the impact these approaches might have on employment, particularly in small business.

I particularly relate to that because of my own State, where we have 26 percent of the people without health insurance. And if we do a mandate coverage by small business, it would have quite a major impact there.

It is also argued—and I think it is legitimate—that we have many unnecessary administrative costs. Great duplication; incredible variation. And that is a flaw of any health care plan that maintains a multiple payer system.

We have a number of expert witnesses with us today to discuss these issues. Mr. Peter Magowan, president and chief executive officer of Safeway, speaking on behalf of the National Leadership Coalition for Health Care Reform; Mr. Bernard Tresnowski, who is the president of Blue Cross and Blue Shield Association; and Mr. John Motley, of the National Federation of Independent Business, and others.

I look forward to hearing from all of the witnesses today about what we can do to help Americans get the best in health care at an affordable price. And once I have learned the best of each system, I may introduce my own. [Laughter.]

Senator Packwood.

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

Senator PACKWOOD. Mr. Chairman, thank you. As we start these hearings today, we clearly look forward to discussing the employer plans and the government run single-payer plans. Also, the administration would basically have individuals provide most of their own insurance through tax credits, or, to the extent that it was not provided by employers, the administration tilts heavily toward individuals.

Each of the plans has some merit, although I think the demerits of a single-payer system are overwhelming. If we are talking about the Federal Government wiping out all insurance in this country, and all of the people that work for the insurance companies, and we are going to collect all of the money and pay all of the bills from Washington, DC—I think Dr. Sullivan said it very well that that kind of a system would have the compassion of the IRS and the efficiency of the Post Office.

I have introduced the Comprehensive Health Insurance Plan, CHIP, of 1991, which bears a direct lineal ancestry to the bill I introduced on behalf of President Nixon in 1973.

It requires employers to provide coverage for their employees. Smaller employers get tax credits to ease them into it. The coverage is quite complete; it covers both full-time and part-time employees, as defined; it includes preventive care. In every sense, it is a comprehensive bill.

It is what we would call a play-only bill. The employers are not allowed to opt out, and, instead, pay a tax and have a public plan pick up that portion of it.

The reason I have excluded that is that I fear, in that kind of a plan, the employers are going to do adverse selection. Those with younger employees who are healthy will cover them, and those who have older employees, or for whatever reason a variety of sicker employees will opt out and pay the tax.

The tax will not pay the cost of the government program. And we will end up with the same problems we have had in Medicare about who should pay how much, and where should it come from.

So, I think, as the Chairman said, there is much good in a number of these plans. And I am frankly delighted that on the Senate side, the majority, both Republican and Democrat, at least seems to tilt toward the concept of employer payment.

I take my hat off to Senator Mitchell for the plan that he has introduced. Employer payment and employer coverage, with the government, really, as a last- resort coverer, rather than primary.

But if we are going to have a single-payer plan—and I know we will have hearings on that—which will cover all of the health costs in this Nation—I would hope that the proponents would at least address themselves to two issues on it, that they really need all coverage—the Federal Government will say someplace between—or total health costs, I should say, in this country this year will be someplace between $820 and $830 billion a year. And the Federal Government, at the moment, is paying roughly $230 or $240 billion in health care costs.

So, if we are going to shoulder an additional $600 billion, roughly, in costs, I would like to know who is going to pay for it. And I know the argument that is made. We will no longer have any health insurance premiums to pay; individuals will no longer pay, the government will pay the whole thing. And that is fine.

But if we are going to have $600 billion in additional cost that we are going to pay for, there is clearly going to be a shift in who is paying.

And whether that is going to be an immense increase in the payroll tax, or an immense increase in income taxes, or some kind of new value-added tax, in fairness, I think the proponents ought to

say what is the method of paying rather than simply saying, well, those who are now paying will not have to.

The other thing they need to address themselves to, if possible, is if we are going to have the government pay all bills from dollar one for all health coverage. Can they conceivably give any estimate as to increased utilization if we have a system where the individual is utterly not responsible for any costs and is entitled to all treatment to be paid for fully by the Federal Government? That is my grave misgiving about that kind of a plan, let alone the fact that I think it cannot be administered fairly under any circumstances.

I would much prefer the employer-based plan. My preference is play only, but I am amenable to discussing pay-or-play, so long as we do not tilt the system in such a way that it is too easy for the employer to get out of the play part and pay.

As I say, the government will get the worst risks, and I wager that whatever tax we have to pay for that part of the plan when we start will not be enough in the way of revenues in a very short period of time.

I thank the Chair. I think these are going to be the most important hearings we will have on this subject this year, Mr. Chairman.

The CHAIRMAN. Thank you. Well, we are fortunate this morning to have the Majority Leader. The Majority Leader, along with all of his other responsibilities, has become a very sophisticated student of this subject and has been a major player in trying to find the proper solution to it, and has joined in the authorship of a major piece of legislation in this regard. We are delighted to have you.

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

Senator MITCHELL. Mr. Chairman, thank you very much. I begin by commending you for continuing these hearings on comprehensive health care reform. I thank you and Senator Packwood for your interesting and constructive comments.

I look forward to reviewing the testimony of today's hearing, which will focus on proposals that utilize the current employer-based system to assure access to affordable care for all Americans.

Mr. Chairman, I begin by asking unanimous consent that the full text of my statement be placed in the record.

The CHAIRMAN. Without objection, that will be done.

Senator MITCHELL. And, since I must leave to be on the Senate floor shortly, the questions I have for each of the witnesses be submitted to them in writing following the hearing.

The CHAIRMAN. That will be done.

[The questions appear in the appendix.]

Senator MITCHELL. Access to affordable and good quality care should be a right for every American; a fundamental right of every citizen in a democratic society. It is not now that right because a right which cannot be exercised is not a right, it is an illusion.

As many as 37 million Americans have no health care insurance, and millions more have coverage which is inadequate to protect them against the cost of a serious illness.

The rising cost of health insurance threatens coverage for all who are currently insured. Nearly 1 million Americans lose their health

insurance coverage each year, often because their employers drop the coverage because of the rising costs of premiums, or because insurers refuse to cover persons with pre-existing conditions.

The problem of the uninsured is not a problem principally of the unemployed. The two groups are not identical. Two-thirds of the uninsured are working persons or their dependents.

The most effective method of reaching those who lack health coverage is to build upon the existing public-private health care system. An equitable system that assures access for all while controlling costs must ask every employer to share the responsibility of providing health care coverage for their employees and their dependents, while, at the same time providing meaningful assistance to small employers to help them meet this objective.

Last year, I and several of my colleagues on this committee introduced legislation which we call Health America, legislation that would require all employers to either provide health insurance to their employees, or contribute to a public program which will provide coverage.

Building upon the current employer-based system, our proposal guarantees employer-sponsored coverage for all individuals who are working, regardless of their level of their income.

The proposal also guarantees coverage for all individuals who are not working through the creation of a new program which will replace Medicaid.

In order to reach the goal of providing quality, affordable care for all Americans, the legislation has a budgeting and reimbursement structure which will produce significant reductions in the rate of cost increases throughout the system.

The crisis in our Nation's health care system is being fueled by the rapidly escalating cost of providing care. We must control cost. I repeat, we must control cost. There is no more important objective in health care reform than controlling the cost.

While I believe Health America includes the necessary provisions to address the health care crisis and reform our failing system, I recognize that it is but one of many proposals.

I am currently working with a number of my colleagues in the Senate to attempt to develop a consensus for comprehensive reform. I am optimistic about our ability to reach that consensus. The time to act is now. I look forward to the testimony to be presented by today's witnesses.

And, Mr. Chairman, before I leave, I especially want to commend Dr. Simmons and his organization for the very careful and thoughtful analysis and approach they have taken to the problem.

And I apologize to each of the witnesses that I am not able to stay to hear their testimony, but I will review it carefully. I thank you for your contribution. Thank you, Mr. Chairman.

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

The CHAIRMAN. Senator Riegle.

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

Senator RIEGLE. Thank you very much, Mr. Chairman. I appreciate your leadership in pressing ahead in this area. I want to follow the remarks of Senator Mitchell.

The bill that he and I and Senators Kennedy and Rockefeller have put forward, I think, is a very rational, very sensible way to attack this problem and to substantially improve it. In particular, we have a strong system of cost control that comes into place.

Today, one of the witnesses, Mr. John Sheils, from Lewin-ICF, will indicate that in terms of the independent cost estimates they have done of our bill, if you take the cost control features as originally drafted, that organization estimates a saving over 5 years of about $80 billion.

That bill has been reported out of the Senate Labor Committee, however, in a form where the cost controls are even tougher, yielding a projected savings over 5 years of $260 billion.

So, I think this is a direction that we must move with respect to tightening down these costs. At the same time, we open up access into the system.

I brought a clipping today of a story that ran in one of the Detroit newspapers about a single parent woman who works and has a modest income. She has some partial health insurance through her work place, but her 6-year-old son, Anthony, has no coverage. She cannot afford it separately because it is just too expensive; and is not provided through her work coverage. And in our system today we provide no coverage whatsoever for youngsters in this kind of situation.

In fact, we have about 300,000 children in the State of Michigan today who are in Anthony's situation where they need health protection. The story goes on to describe how the mother is working as hard as she can. They live in a house trailer.

She lays awake at night worrying about what happens if she gets sick again, as she has been before, or, if her son gets sick, how that problem is to be met.

In 1992 in America, we do not have to have that situation. And every other country in the world has found a way now to provide a health insurance plan for its people, and it is a wonderful investment.

Investing in our people and investing in good health is a bargain because we are either going to invest in good health, or we are going to ignore the investment and end up with bad health. And then we end up paying the bill later, and it is far more expensive, industry tremendous suffering and hardship along the way.

So, I want to draw attention to the supportive testimony that you will be hearing from Lewin-ICF this morning. Also, the representatives from the National Leadership Coalition, the Pediatricians, and the College of Physicians, will also have important supportive comments to make.

But, finally, I think it is very important that this gridlock over which approach is best be broken, because we cannot just continue in a situation where the cost of health care as a percent of the GNP is rising as much as 2 percentage points a year. We are spending over $800 billion a year.

It is the number one problem facing American businesses, large, medium, and small. They are coming to see us every single day begging for some kind of a rational overhaul of the health care system.

Businesses want to provide health insurance for their workers. Increasingly, they just cannot afford to do it. The cost shifting that comes in as a premium on top is just breaking the back of more and more businesses, and we can do something about it.

So, I recommend our plan, Mr. Chairman. I do not say it is perfect. I agree with the comments that Senator Packwood has made, and my memory goes back, as we served together back in 1973, and I remember those initiatives at that time.

We have lost two decades since that time. And I do not think we can continue to have this happen. I think the country wants a response.

I think we ought to be able to find a way to craft something that is practical and that gives us the cost control impact and broadens out the coverage so kids like Anthony, here, can be part of this system of ours the way they should be. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Breaux, for any comments you might have.

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

Senator BREAUX. Thank you. Very briefly, I commend you for, I think, approaching a conclusion to these hearings, in the sense that we have heard a number of ideas. We probably have as many ideas as we have Members of Congress, which I guess is part of the problem, as well as part of the solution.

But I think we are moving to the point of having to start picking and choosing and sitting down and writing a plan. We have studied it enough. We have had all the reports, we have had everybody present testimony.

With this hearing, we will have completed the process of hearing from people who have the ideas, and we are going to have to sit down and put them down on paper. Hopefully, we will be able to accomplish that this year.

I have an idea that is part of the solution, in my opinion, not the whole solution. That is a medical care savings account where employers would give more discretion and flexibility to each employee to make their own decisions about purchasing health care services.

Knowing that it is their savings accounts, they then become, I think, more responsible, more wise in how they shop for medical care, and how they use those medical care dollars if they know that it is something that really belongs to them.

I am really concerned by the fact that many people, as long as they think a third person somewhere else is paying for it, whether it is the employer or the government, are not as conscious of their spending when they have insurance as they would be if, in fact, they had more control over those funds and know that they were actually spending their money. So, that is one aspect that I hope to pursue while we move towards a comprehensive solution. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Daschle, for any comments you might have.

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Thank you, Mr. Chairman. I, too, would commend you for again demonstrating your leadership and commitment to this issue by holding this second in a series of hearings on health care. I would like to make three quick points.

The first, is that, as we consider all of the different possibilities to solve the problem, I hope that we all agree on what the problem is.

And, frankly, I do not think that there is a consensus as to how we describe the problem. I believe that there are several aspects to the problem.

Obviously, everyone agrees on cost and access as two of the major problems, but I do not see to the degree I would like discussion about the allocation of what we spend. We misallocate so many of our dollars today, and that has to be addressed.

We misallocate too much to paper work and administrative cost. In my view, we misallocate too much to the most expensive end of the health care delivery system.

The GAO was here just a couple of weeks ago to say that we misallocate as much as $70 billion to fraud because, in large measure, we have a multi-payer system. So, there is a misallocation of resources that we have got to address more effectively.

There also is a too high a degree of unnecessary care provided in our system today. Arnold Relman says that it is much as 30 percent. I think we have to address unnecessary care a lot more effectively. And then, finally, the hassle factor.

I hope that the committee, as we consider the solutions, will lay the solutions against the problems and ask ourselves in each one of these cases, how does your solution address those particular problems?

The second point, is that I do not think that we ought to be distracted by the method of payment. I think we should be more concerned about the cost of the whole system. I happen to favor a shift from a private premium to a public premium. But, overall, we ought to consider what is the most efficient method by which to collect the resources necessary to make this system work more effectively.

The third point, is that we should also consider whose responsibility it ought to be to provide health care in this country. If we were going to start from scratch, if we were the founding fathers and we were debating this issue, and the question was, we have got a choice here: we ought to make it a responsibility of the employers, or we ought to make it a responsibility of the community. If we really debated that question, I dare say everyone, including all the employers, would favor that responsibility being put on the shoulders of the community, not the employer.

Every other society has come to that conclusion, and I would hope that ultimately we will, too. Health insurance coverage ought not be an employer responsibility. I share the Majority Leader's optimism that we do see a consensus forming, at long last.

And I think there ought to be several characteristics that are included in any plan we ultimately develop. It ought to have effective cost control; it ought to guarantee access; we ought to utilize the technology that we have so available in this society; we ought to utilize the private sector to the degree it is possible; we ought to ensure personal choice; there ought to be portability; and, finally, we have got to emphasize wellness promotion a lot more than we have in the past.

So, I hope that we consider these points and I am impressed with the impressive array of witnesses we have this morning, Mr. Chairman, and again commend you for the hearing.

The CHAIRMAN. Thank you.

Senator Grassley.

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

Senator GRASSLEY. Mr. Chairman, we have had a number of hearings on this issue and I have nothing to add at the moment to what I have said at our earlier meeting. Thank you for holding these hearings and making the process work I am going to put my complete statement in the record.

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

The CHAIRMAN. Thank you very much, Senator. Mr. Magowan, if you would proceed, please.

STATEMENT OF PETER MAGOWAN, CHAIRMAN, PRESIDENT, AND CHIEF EXECUTIVE OFFICER, SAFEWAY, INC., OAKLAND, CA, ACCOMPANIED BY RON ZACHARY, VICE PRESIDENT FOR HUMAN RESOURCES, SAFEWAY INC.; AND HENRY E. SIMMONS, M.D., PRESIDENT, THE NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

Mr. MAGOWAN. Mr. Chairman and members of the committee, thank you for this opportunity to speak with you about health care reform. I am here on behalf of the National Leadership Coalition of Health Care Reform. With me is Dr. Henry Simmons, president of the coalition, and Ron Zachary, on my right, senior vice president of Human Resources at Safeway.

By way of background, Safeway is the Nation's third-largest supermarket chain. We operate some 875 stores in 17 States and the District of Columbia, together with an extensive network of distribution and manufacturing facilities. We are a highly labor-intensive company, with approximately 110,000 employees.

I am here today because, as the CEO of a major corporation, I am very concerned about the health of our employees and about the financial health of our company and industry.

Last year, Safeway's cost for providing health coverage to our employees and their dependents was almost $225 million. That was more than four times our net profit for the year.

Especially with health care costs spiraling up so rapidly, these numbers are alarming and they are unsustainable. That is why I am actively involved in the National Leadership Coalition.

The coalition includes companies, unions, consumer and other not-for-profit groups, and associations of health care providers. We

are the largest and broadest private-sector alliance in support of comprehensive health care reform.

Last November, we proposed a package of reforms that would guarantee health coverage to all Americans, include the quality of the care they receive, and control costs.

We estimate that our cost control mechanisms, including expenditure targets that ratchet down the rate of growth 2 percentage points a year and fee schedules, to keep spending at or below those targets would cut America's health care bill, compared with what we have spent in an unreformed system, $600 billion a year by the end of this decade.

Our plan's guarantee of universal coverage builds on the current employer- based system and it includes what has come to be called a play-or-pay mechanism. But let us be clear on one point: play-or-pay is not the plan. It is just one piece of a broader package of reforms.

I can say that because I have noticed a tendency among some participants in the health care debate to over-simplify, to assume that someone, somewhere has proposed a plan that has nothing more in it than a play-or-pay provision.

To the best of my knowledge, nobody has. We certainly have not, as my written statement, which includes a detailed description of our eight-part plan makes clear.

Our plan was built on four principles, and we would commend them to the committee. The first, is that health care reform has to address all three parts of the health care crisis concurrently—access, quality, and cost—and not just because we need progress on all three fronts.

This huge sub-economy we call the health care system is extraordinarily interdependent. If we proceed with partial reform, if we address only one component of the crisis, we will wind up just making the other two pieces of the problem worse.

For example, a major expansion of access without concurrent improvements in quality and effective cost control would result in more people receiving lower quality care at a much higher overall cost.

Similarly, tough cost control by itself, unaccompanied by other measures, would reduce both access and quality. And an effort to bolster quality without attending to the other dimensions of the health care crisis would drive up costs and further constrain access.

The second principle that our plan is based on is our view that health care reform has to work across the whole health care system if it is to be effective.

As our experience with cost constraints and Federal health care programs makes clear, if reform is not systemwide, gaining in one piece of the system will just be offset by losses elsewhere.

Third, we believe that reform should build on the strengths of the present system. Health care reform is a delicate balancing act. We ought to make sure that in trying to create a better health care system for the future we do not undermine our capacity to meet the health care needs of our current population.

That is why the coalition, in considering possible plans for reforms, focused on alternatives that did not involve the potential for major disruption in the delivery of health care.

We decided to craft a proposal that builds on current institutional arrangements rather than trying to replace them all at once with one model or another of health care delivery.

We decided, as well, to build around current financial arrangements rather than propose a wholly new financial structure, such as a national health insurance system that could require large tax increases and economic dislocations.

Right now, 70 percent of the Americans who have health coverage receive it through their employers. That is the central characteristic of the American way of financing health insurance. We think it makes good sense as a matter of practicality and prudence to construct a system for universal coverage that pivots around this existing base. In this sense, the employer-based system we propose is an evolution, not a revolution.

And, fourth, we cannot afford to gamble with the health care system. Some reform proposals center on devices that have not been tested yet or much in the real world.

The coalition believes that we ought to err on the side of caution. There is just too much at stake in the health care system for the health of Americans and the vigor of our economy to take unnecessary risks.

In this respect, the coalition's plan may fairly be described as conservative. It draws on techniques that have already been tried and have succeeded in several States, in other nations, and in the private sector.

Our plan satisfies the four principles I have just described. It addresses all three dimensions. I am through in about a minute, Mr. Chairman.

The CHAIRMAN. Go ahead.

Mr. MAGOWAN. It addresses all three dimensions of the health care crisis; it is systemwide; it builds on and around the strengths of the present system; it is prudent; and it meets another standard for reform, as well. It has commanded support from an extraordinary range of interests.

I hope that as the health care debate moves forward we can start to dispense with some of the artificial categories that divide advocates of reform instead of bringing us together.

The coalition's plan is, in fact, a hybrid of competition and regulation; of private-sector empowerment and public-sector assurance of economic, legal, and social policy reforms.

And the reason is very simple: this is a plan that was put together by pragmatists. It was not designed for ideological purity. It was designed to work.

One last thought. The need for health care reform is truly urgent. Every year we delay effective cost control, total U.S. health care spending jumps 12 to 13 percent, siphoning off capital that is needed to finance economic growth, putting American companies at a growing cost disadvantage in world markets, and enormously complicating our efforts to tame the deficit.

Every year we delay universal coverage, more Americans join the tens of millions already living on the edge without health insur-

ance. And every year we delay initiatives to improve quality, more of us risk mortal harm from sub- standard care.

We know that this relentless accumulation of cost, and fear, and danger cannot be allowed to continue indefinitely. Let us work together—the public sector and private sector are cross divisions of partisanship and idealogy—now, before the crisis gets even worse. Thank you very much.

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

The CHAIRMAN. Let me understand. If you had tried to work out a balance where approximately one-third of the employers would go for the public program, do you have other sources of revenue for people who are not covered at the present time? How do you think their health insurance should be paid for? I am not talking about those that are employer-based, I am talking about otherwise.

Mr. MAGOWAN. We estimate that about three-quarters of everybody would be paid for by employers, under our proposals.

The CHAIRMAN. Right. Right now, it is about 70 percent, which is what you said earlier, I guess. All right. Where would you go for the rest of that money?

Dr. SIMMONS. Well, that is the 0.5 percent payroll tax levied on all employers and all employees, Mr. Chairman. In fact, every American above the level of 200 percent of poverty, and every employer would pay 0.5 percent of payroll, up to 200 percent of poverty.

The CHAIRMAN. So, you would just let Medicaid take care of the rest, in effect?

Dr. SIMMONS. Medicaid would be subsumed into our program, the acute care provision; Medicare would remain a freestanding program.

The CHAIRMAN. Give me some of your feelings. We get so much complaint from the providers about the multiplicity of forms, the duplication, the complexity. What do you do to take care of that kind of problem? I guess you get a fairly substantial change in the number of employees going from one job to another.

Mr. MAGOWAN. If we had a standard medical plan with sort of a standard insurance form instead of 1,500 different insurance companies coming up with 1,500 different, individual insurance forms, that would be a big step in the right direction.

If everybody was admitted into these hospitals without the hospitals saying, do you have coverage, or you do not have, admissions would be much simpler. The fact that it would be simpler would also lower the cost of admissions into the hospitals.

The CHAIRMAN. Amplify a little more on your cost containment for me, as to how you think that would be accomplished.

Mr. MAGOWAN. Well, we set targets that are 2 percent less than the overall rate of inflation, each year ratcheting down the overall rate of cost that we will tolerate to be 2 percent less than the overall rate of inflation in the country.

The CHAIRMAN. Who enforces that?

Mr. MAGOWAN. There is a national health board that would be comprised of individuals representing consumer groups, government, the providers, corporations, that would have overall supervisory responsibility.

The CHAIRMAN. Would that get into the capital costs of the hospitals?

Mr. MAGOWAN. Well, first of all, it would set rates and fee schedules that would, if met, result in this lower cost. Then it would be up to the local States to come in under those targets. So, they would have to look at all elements of waste in the system, and there are many things that we think would come about as a result.

For example, 20–30 percent of all procedures done in this country probably do not need to be done. Malpractice insurance reform is a big part of our cost containment effort.

Simplification of administration would also reduce these costs. We pay 18–24 percent of the total cost in administration. In Canada, it is around 11 percent, just because it is simpler.

The CHAIRMAN. When you put this kind of additional cost on small employers who are not carrying this insurance at the present time, would you anticipate that this would result in an increase in wholesale prices?

Mr. MAGOWAN. Well, first of all, Mr. Chairman, I think that it should be pointed out that 90 percent of small business that employs 25 or more people does provide insurance. If we are talking about small business at 10 employees or above, 75 percent of them do provide insurance. So, most small business is now providing insurance. But those that are not——

The CHAIRMAN. Yes. But a lot of that is just partial insurance. A lot of it does not cover dependents.

Mr. MAGOWAN. Excuse me. Does not cover what?

The CHAIRMAN. Does not cover the dependents. A lot of it.

Mr. MAGOWAN. Well, I think for those that are now not providing insurance, people worry, is this going to suddenly result in a large extra cost for them. Maybe initially before the reforms actually kick in there would be some additional extra cost.

We estimate the total cost of putting the system in in the first year is an extra $35 billion. But, in the second year, we estimate savings of $40 billion, and, by the end of the decade, savings of $600 billion.

So, even if there is some initial cost, there is going to be substantial reductions in the later years. I think a lot of small business has not signed up for insurance because they are so worried about the extra costs that they would have to face.

Many small businesses are discriminated against by the insurance companies that base the rating for them on past experience of that company, or for other similar small businesses.

The CHAIRMAN. We have passed legislation through this committee and through the Senate that would address that particular problem for small business.

Mr. MAGOWAN. And that would be a big help for small business. A small business in the bay area would pay insurance on the same basis that big companies like Safeway do.

Dr. SIMMONS. It is gratifying, Mr. Chairman, that a number of important small business groups are now advocating some of the strong cost containment strategies that the democratic proposal has talked about by Congressman Rostenkowski and others, including budgets, expenditure targets, and capital allocation.

So, small business, I think, understands every bit as much as the members of this committee how important it is to control costs with new, much tougher techniques.

Mr. MAGOWAN. I might add, I think the State of Hawaii has a lot of small businesses. And they have been with an employer-based system for what, Henry, 20 years? And I do not think that you could make an argument that the economy has suffered as a result of that.

The CHAIRMAN. Well, and I guess they are down to two or three insurance companies, are they not?

Mr. MAGOWAN. That, I do not know.

The CHAIRMAN. Yes. I think that is about right. We particularly looked at some of the efforts of the States. Hawaii has a particularly interesting set of numbers.

Senator Packwood.

Senator PACKWOOD. Mr. Magowan, let me make sure I understand. You hope to be able to restrain medical costs to 2 percent below inflation each year.

Mr. MAGOWAN. Two percent below each year.

Senator PACKWOOD. So, if inflation is 4 percent next year, you would hope to hold medical increase to 2 percent.

Mr. MAGOWAN. Correct.

Senator PACKWOOD. Whereas, it has been running normally 5, 6, 7 points above inflation right now.

Mr. MAGOWAN. That is correct.

Senator PACKWOOD. That is a laudable goal. And I heard what you said in response to the Chairman's question on enforcement, but be a little more specific.

You are this National board, and the hospital in Burns, Oregon wants to have a CAT scanner and somebody else wants to have some kind of a machine in Bend, OR, and you have got something in Poughkeepsie, NY, that wants to change.

How do you enforce, how do you supervise all of these costs so that you are weighing what you are going to reimburse an anesthesiologist, versus the cost of a CAT scanner, and make it all squeeze into the 2 percent below inflation lid?

Mr. MAGOWAN. Senator, I do not think we understood your question. It is not 2 percent below inflation, it is cutting 2 percent of the total growth each year until we reach the level of GNP or GDP growth, if you choose to do that.

Senator PACKWOOD. Now, say that again.

Mr. MAGOWAN. It is cutting the total spending 2 percent a year.

Senator PACKWOOD. Right.

Mr. MAGOWAN. Not just the inflation rate, but 2 percent of the total costs each year until total health care costs reach the level of GNP growth. At that point, this independent commission that we recommend putting in place will make the societal decision, can we cut low, or do we need more, is there an epidemic. But that will be a societal judgment there, authorized to make.

Senator PACKWOOD. All right. Now, let us round it off. Say the total health care costs in this country are $800 billion.

Mr. MAGOWAN. Right.

Senator PACKWOOD. What would you hope it would be next year? $800 billion less 2 percent?

Mr. MAGOWAN. That is · ght.

Senator PACKWOOD. So, rather than going up 10 or 11 percent, which is what they have been doing, up $80 billion, you would hope to cut it by $16 billion.

Mr. MAGOWAN. By 2 percent each year.

Senator PACKWOOD. Or almost in the first year a $100 billion cut from where we would otherwise be but for some controls.

Mr. MAGOWAN. By the second year; that is right.

Senator PACKWOOD. All right. Now, how is that——

Mr. MAGOWAN. This is the chart that demonstrates that.

Senator PACKWOOD. I understand the demonstration. Of course, you and I have met several times, and, frankly, I am impressed with your plan. But I want to know now the method of enforcement.

Mr. MAGOWAN. All right.

Senator PACKWOOD. As to how we get these costs now down just $16 billion, but down $100 billion from where they would otherwise be, because you are going to get them down the $800 billion figure.

Mr. MAGOWAN. That is right. Well, Senator, we would basically use three techniques, two of which you are currently now using in the Medicare program. That would be the DRG system, with its update, the physician payment referral with its RBRVS, and the expenditure target. Those are part of the techniques that are used in our cost control mechanism.

They would be similar to those that have been used in State hospital rate setting effectively in the States of Maryland, New Jersey, Massachusetts, and New York, and have some similarity to those mechanisms that are effectively used and have a track record of success in West Germany, France, Japan, and even Canada.

So, those are the tools. We are not talking about untested, dream theories here. Those are the techniques that would be authorized to be used to establish the expenditure target, to couple that with a rate-setting mechanism using the RBRVS that would meet the expenditure target and a capital allocation mechanism similar to that which you have authorized now for the use of Medicare.

So, those are the techniques that are established in this system except with Medicare has not worked if you meant reduced the actual expenditures. We have not succeeded in doing that.

Dr. SIMMONS. Well, first of all, Senator, I think we cannot make that statement in PHYSPRPPAC because that has just become authorized to be the law of the land in late 1991, 1992. So, it is too early to know that.

There, we would have to go on the experience of the States that have done it and of other nations that have done it. But I believe that the studies that GAO and CBO have made, and the reports that we have had back from Physician Payment Reform and the Prospective Payment Assessment Commission are that the evidence is that they have definitely cut the rate of growth of Medicare spending. Total cost, no.

Senator PACKWOOD. Total cost, no. And part of the problem is volume. No matter how much you cut if you have twice as many tests as you used to have, your costs are probably going to go up no matter how much you cut the reimbursement for the costs.

Dr. SIMMONS. Right.

Senator PACKWOOD. But what you are saying is very similar to what Dick Darman said several years ago, and I think you mean the same. He said, next year, what we propose is we are only going to spend X amount of dollars on Medicare, and that is all we are going to spend. And if that does not cover everything, we are going to allocate it among the different providers, hospitals.

Dr. SIMMONS. Yes.

Senator PACKWOOD. And if somebody thought they were going to be reimbursed $500,000 for a CAT scanner and there is not enough money, they only get reimbursed $375,000.

Dr. SIMMONS. Right. Which is exactly the way other nations have gone about it.

Senator PACKWOOD. But I want to make sure that everyone understands exactly what you are saying. This super board is literally going to allocate on that basis.

And if you say we spend $800 billion this year and we are going to spend $784 billion next year—we would have otherwise spent about $880, so you are going to cut roughly $100 billion—we are going to cut the cloth to fit the budget.

Dr. SIMMONS. Right.

Senator PACKWOOD. All right.

Dr. SIMMONS. But, could I make, just for the record, a clarifying statement on the expenditure target budget allocation? Basically, it is this: we would call for the board being authorized to drop the rate of growth 2 percent a year until it is equal to the rate of GNP.

Further translated, if the rate of growth now, which is, 12 percent a year—it is supposed to be 12–15 percent a year over the next 5 years, according to Commerce—next year we would factor in a rate of growth of 10 percent, the following year, 8 percent, until we go down to GNP growth.

Then a societal decision is made: should we spend more, should we spend less, should we stay on target. And basically what West Germany has succeeded in doing is keeping the rate of growth commensurate with the rate of growth of GNP or GDP.

Mr. MAGOWAN. Medicare and Medicaid have done a pretty good job in the last couple of years of lowering that rate of growth through target setting. The problem has been, though, that it has just gotten shifted into the private sector.

If the doctors do not get enough income from serving the Medicare and Medicaid patients, they are raising their rates, hospitals are raising their rates to cover for it.

Senator PACKWOOD. Under your plan, I think I am inclined to agree, you are going to have to limit that increase, also. They will not be able to shift it.

Dr. SIMMONS. Oh, yes. That is the total factor of our plan, Senator. Cost-shifting is gone. There is no ability to cost-shift. You now have a level playing field. Government does not control its problem by shifting to the private sector.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. All right. Thank you. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman, and thank the panel for their presentation. Some argue that it should not be an employer's obligation to provide health insurance for their employees. I take it your position is just the opposite.

Mr. MAGOWAN. That is correct.

Senator BREAUX. That it is an obligation of the employer to provide basic health benefits.

Mr. MAGOWAN. I think not only is it an obligation, but I think it is the best way of having a more efficient system. I think it would be a more efficient system than if the government does it.

Senator BREAUX. Let me ask, just to get a little discussion here, on the question of caps on medical care costs which this commission, as I understand your plan, would come up with in order to control costs.

Explain for me. You are in the grocery business in a major way. Suppose people came to Congress and said, look, grocery prices are too high, set up a commission and control prices of groceries. I mean, give me a comparison of why it is all right in this area, or would you agree that it would be the right thing to do in your business, as well?

Mr. MAGOWAN. I would be opposed to price controls under any circumstances by themselves. But that is not what we are talking about. We are talking about price controls that are working in conjunction with cost controls.

If you want to set up price controls in the grocery business and you have got some method of setting up cost controls in it at the same time, then let us talk about it.

But what we are trying to do with the health care proposals is to link rate setting mechanisms, fee targets, et cetera, with very tough, strict cost controls. Price controls, by themselves, I think, would not be in anybody's best interest.

Dr. SIMMONS. Senator——

Senator BREAUX. Let me follow up on this point and I will let you speak. How do you control the cost of the hospitals, and equipment, and the buildings? You are controlling what they can charge, but how do you control the end costs that they have to incur and now pass on to the consumer?

Mr. MAGOWAN. Henry, could you address the details of that?

Dr. SIMMONS. I am sorry, Senator, I was thinking of a previous question. Could you repeat it? My apologies.

Senator BREAUX. How do you control the cost that the providers have to incur and are now passing on to the consumers, costs like the equipment they buy, the drugs they buy, the salaries they pay for nurses, doctors, et cetera, in order to have a cost control program?

Dr. SIMMONS. Well, in our mechanism we do not. What we say to those that provide the care is that this is the amount of money that we payers have available.

Now, you have to work within that and figure out a way to more efficiently develop the product, which is basically the way each of the States have done it, and the way other nations have done it.

But, to go back to your question as to whether the grocery business would be under price or cost controls, I think the difference in those two industries is, in the grocery business, it is a lot easier and it really, truly is a highly competitive business, competing on quality and cost with a knowledgeable consumer.

I can go into Safeway and see a unit price, and I can taste the food and I can make a fairly good judgment, was it worth what I paid for it.

We do not have those kinds of conditions in the health care system, and that is why we felt we have had to reach for these new mechanisms to control costs. We just have a less than ideal market here that will not self-correct itself, in our judgment.

Senator BREAUX. Let me ask you, then, because I think it fits nicely into the concept or the thought that I have been working on for a medical care savings account.

How much does Safeway, if you have a figure, on average, pay for a premium for your workers, do you know?

Mr. MAGOWAN. Mr. Zachary.

Mr. ZACHARY. Senator, it is about $2,700 a year, including dependent coverage.

Senator BREAUX. All right. People tell me that 97 percent of the people in America spend less than that $3,000 a year on health care. Suppose you just gave that $2,700, or, say, a portion of that to your employee and let them make the decision on where they want to spend it, and then use the remainder to buy a catastrophic policy for them.

What are your thoughts on that type of a medical care savings account where the employee would have that account and be able to use it as he or she felt was in their best interests?

Mr. ZACHARY. Part of the difficulty is really whether or not they are a wise consumer. And the idea of educating all of the employees in terms of what are the best plans, and so on and so forth, I think, is one of the major difficulties with that.

Senator BREAUX. Well, there is no choice in that now as long as a third person is paying for it. Right?

Mr. ZACHARY. Well, there are selection processes now between HMOs and fee-for-service, and employees can make those kinds of decisions. But to get into that, I think, is adding another layer of complication on the system.

Senator BREAUX. It eliminates a lot of paperwork and bureaucracy as well, though, does it not? I mean, you do not have to fill out an insurance form if a person has his account and can just go pay his bill with it.

Dr. SIMMONS. Well, the insurance forms still exist on the other end. I mean, I do not see how that can——

Senator BREAUX. No, no. Well, we can talk about it. It would not. If a person has his account, he goes to the doctor, he pays the doctor; he goes to the drug store, he pays the drug store. He does not have to submit a form. It is his account; it is his money. Insurance is not involved in the paperwork on that system. All right. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Mr. Magowan, you made an interesting statement just a minute ago that you think that what you are suggesting is a much more efficient system than if government does it.

As I look at all of the systems around the world and the degree to which government does it in those systems, I look at the administrative costs, I look at the access, I look at the degree of con-

fidence that they have in cost containment, it seems to be directly in conflict with the statement you just made. Perhaps you could elaborate a little bit on what it was you meant by that statement.

Mr. MAGOWAN. What I meant was that in many countries—Germany and France would be two examples—they are employer-based. It is not up to the government.

It is up to the government in the U.K., it is up to the government in Canada. In both cases, in the U.K. and in Canada, one of the elements that has been a result is rationing.

And we hear stories about people crossing the border from Canada, for example. They cannot get services in Canada, waits in line, people waiting a year for the hip replacement that they want.

There has been a fair amount of criticism of the state health plan in the U.K. for more of these kinds of reasons. It does have the advantage of having much lower costs, and it does have the advantage of full access.

Whether it has as much quality in their systems as in our system now is, I think, a good question. Germany and Japan, I think, come closer to providing that combination of all three things: better quality, complete universal access, and at reasonable cost.

Senator DASCHLE. Would you like to see the degree of government control in our system that Germany uses in its system?

Mr. MAGOWAN. I would be absolutely willing to put up with the degree of control by the government in Germany. It is relatively small in Germany. It is employer-based in Germany, and it is employer-based in Japan. It is employer-based in France.

Dr. SIMMONS. Senator, in further answer to your question on administrative simplification—you and I have had this discussion—we have thought very carefully about how we could optimally capture the major amount of waste in the system now which you know exists.

Actually, as we have done the analysis, once you have a standard benefit package which our plan calls for, as does yours, once you have a standard benefit package as our plans calls for, as does yours, once you have a uniform claim form, once you have eliminated medical underwriting, then you really have captured a very substantial part of the possible administrative simplifications without going to a single-payer system, in our judgment. And we have run these analyses, and there are very major savings here.

Now, whether they are quite as large as a single-payer, we would not argue with you. But the other point we would make is, single-payer brings some baggage with it which we believe our proposals does not, and we could debate the strengths or weaknesses of that.

But there are substantial savings in administrative simplification available without going to a single-payer system, in our judgment.

Senator DASCHLE. To what degree do you believe you can save administrative costs with the system you are suggesting?

Dr. SIMMONS. What level of dollars?

Senator DASCHLE. What percentage?

Dr. SIMMONS. Well, we have those figures.

Senator DASCHLE. If administrative costs are currently between 18 and 24 percent, what percentage do you think we will have if we fully implement your system?

Dr. SIMMONS. Well, many billions is as many as I could say, Senator Daschle.

Mr. MAGOWAN. Well, we said, did we not, $600 billion by the end of the decade over what they would otherwise be.

Senator DASCHLE. That really does not help us because we do know——

Mr. MAGOWAN. I think the Senator is talking about administrative savings.

Senator DASCHLE. Exactly.

Dr. SIMMONS. I do not have that figure, Senator.

Senator DASCHLE. Could I ask you, following up a little bit on Senator Packwood's question. I am still troubled a little bit by this enforcement mechanism, as well. You said expenditure targets, and I understand that, and I understand the mechanisms by which you hope to achieve those targets.

But what mechanism will give you the confidence that you are going to hit those targets? How does the board work in that regard?

Dr. SIMMONS. Well, whether it hits the target is obviously important, but does not cripple the system if they do not.

Because basically the way it works, which is the way you have designed physician payment reform and the way the West Germans and others do it, if you do not hit the target that year, then the rate next year is adjusted so that you retroactively make up for the shortfall, which is an advantage over a budget. A budget, if you run out of money in November, you do not pay for any care in December.

Well, we do not think that is workable, and that is why we picked the expenditure target rule, so it self-corrects a year after the fact so you cannot game the system that way.

Senator DASCHLE. Well, I am out of time. I would only say one thing, and I really hope that we consider this as we go through this. I remember in the Cold War days that we would always fault the Soviet Union for having this ideological truth.

The ideological truth in the Soviet Union wasG25 that capitalism was bad, and, by God, the U.S.S.R. and all that it stood for was good and no one could ever defy that truth.

I sense there is a little bit of that going on as we consider health care. Our belief is, by God, we are the best, and in all cases, there is no country that can compare and we ought not to look at other countries and what they have done.

And I think that is a very serious problem. We should not be blind to the savings, if we are blind to the mechanisms by which other countries have addressed these problems much more effectively than have we.

And I think there is some indication that that may be happening as we consider this issue today and I would hope that we would open up and be very objective as we consider the pluses and minuses of our system, and that of others. I thank the panel, and I thank you, Mr. Chairman.

Mr. MAGOWAN. I could not agree with you more. I really feel, Senator, that we do try to do this. We have been up to Canada, we have looked at their system. We met with the representatives from Germany and Japan.

We have done a fair amount of research on this. There are certain elements of all of those systems that are better than ours. We would agree with you. You ask what we pay for administrative costs, I think that 18 to 24 percent of the total cost in the United States is in administrative costs, and in Canada it is around 11 to 13 percent, just across the border. They have a much simpler system, though.

The CHAIRMAN. Could I ask for clarification? You keep using the figure of $600 billion by the end of the decade in savings. Are you talking about cumulative savings from this point until then?

Mr MAGOWAN. No. That would be the saving per year in that last year. If we do nothing about health care costs and they continue to go up in the next 8 years in the decade, as they have been going up, then they will be at $1.9 trillion in the year 2000.

The CHAIRMAN. Mr. Magowan, I have listened to a lot of numbers. That is the biggest one yet insofar as the actual——[Laughter.]

Mr. MAGOWAN. That is what it is if you keep it going at 12 percent. That is what it gets up to, $1.9 trillion. And with our reforms, it would be $1.3 trillion, we think.

The CHAIRMAN. Of course, they are projecting more than 12. We are talking about possibly 14 compounded.

Mr. MAGOWAN. Well, I think this estimate is at 12. Is it not?

Dr. SIMMONS. Yes.

Mr. MAGOWAN. Twelve percent is what gets us to $1.9 trillion.

The CHAIRMAN. I understood that. I understand compound interest very well, too. Thank you. [Laughter.]

Dr. SIMMONS. Actually, Mr. Chairman, the Robert Wood Johnson Foundation figures that they funded are even higher than this, of savings.

The CHAIRMAN. Well, that is right. I have higher numbers insofar as the compound increase. But your $600 billion is the largest cumulative annual estimated savings total I have seen. Go ahead, Senator Grassley.

Senator GRASSLEY. I want to ask about the national board and how it will work in regard to Medicare. Am I right that the Medicare program will be included in the expenditure limits and the payment rates?

Mr. MAGOWAN. Yes.

Senator GRASSLEY. All right. Then, if that is the case, I want to note that most of the providers in my State believe that Medicare and Medicaid do not pay the full cost of providing health care services, and there is furthermore an assertion to that effect in the coalition's short brochure.

So, I presume that including Medicare would be important, otherwise it would continue to under-pay and the providers would not be able to cost-shift to make up for the losses that they sustained in public programs.

Could I assume, therefore, that the board could conceivably end up recommending that Medicare spend more than what we in the Congress and the administration would otherwise be inclined to spend on it?

Dr. SIMMONS. Yes, that is a possibility that this board would recommend that. In fact, in our report, we call for definitely raising Medicaid up above the unrealistically low level that it is now.

Senator GRASSLEY. Yes. Then I guess I would want you to comment on an assertion that I want to make that I think it is quite easy for us to see a little trouble in how Congress and the administration could cede so much authority to an independent board, given that Medicare is such a major part of the Federal budget.

Dr. SIMMONS. Well, Senator, we do not call for the Congress ceding that. We call for the establishment of this board that has the authority to make the recommendation to the Congress.

And, in Nancy Kassenbaum's particular way to treat that, she would say that the commission would present to the Congress its recommendation for the update in the fee schedule, and the Congress and the President would be able to vote up or down on the package, but not amend it.

Now, we have not gone into how that mechanism would be. No. We do not think legally you could ever take that power to tax away from the Congress.

Senator GRASSLEY. All right. So, the national board in regard to Medicare, then, would not be governing the cost and the reimbursement of Medicare, it would be recommending to Congress.

Dr. SIMMONS. Yes. That is built into our proposal.

Senator GRASSLEY. All right. I gather that you have moved away from specifying a predetermined payroll tax rate to finance the program recommended here.

I believe that you said in your statement that the rate would be set at a level that would keep the ratio 3 to 1 between the number in the privately-insured group, and the number in the State-administered program.

Could you tell us why you made this change, and how you settled on the 3 to 1 ratio? And, also, are you able to say what the payroll tax would have to be to maintain this ratio?

Dr. SIMMONS. Senator, this will take a little bit of a more lengthy answer than you want, but our fundamental proposition, the coalition agreed, was that we do not want a program run by the Federal Government.

We have to have important Federal responsibility here, but we would like to keep it predominantly private system under these other elements that would control its problems.

And, therefore, we backed into our strategy, saying if we want a predominantly private mechanism of insurance, and, obviously, private delivery of care, then this tax rate has to be set at a level that would give us about three parts of the total in the private system, and one part of the total in a "public-sponsored" system. We backed into the tax rate necessary to do that.

Now, when we did those figures—and these are now figures from some time past—that is what gave us the tax rate of 71.75. When we did our actuarial analysis, we found, from what average payrolls are, it would give you that kind of a system.

And what that figure would be today since costs have already escalated over $100 and some billion since our report, we do not know. But we do say that the tax should be set at a rate so that

we do not have an all public-sponsored system. That was a basis, a principle which led us to the design of this proposition.

Senator GRASSLEY. You pointed out that criticizing the play-or-pay proposal without taking into account the cost containment features would be unfair and misleading.

Could you tell me and the committee a little bit more about how you would coordinate the implementation of the cost containment elements of the proposal with the implementation of the play-or-pay aspects?

Dr. SIMMONS. Yes. And, again, this will be a judgment that the Congress will have to make as it enacts a proposal, if it does, similar to ours.

Given the serious state of the economy and the deficit, you could preferentially decide to put in the cost controls first and phase in the access so that you do not take on an extra cost until you have generated some savings.

And one of the possible ways that we have looked at internally is to put the cost controls in day one, across the system, and, as savings accumulate, which they would rapidly do, you could then phase in access—women and children—until we have total access. That is one option that the Congress could choose.

Senator GRASSLEY. Mr. Chairman, this is just for clarification. The problem here is so that small business would get the cost containment information and benefits before and not later than they would have to start offering insurance or paying the tax.

Dr. SIMMONS. Yes.

Senator GRASSLEY. You say that takes care of the problem?

Dr. SIMMONS. Well, the way we have designed our program—we heard the concern of small business. They say, why should we have a mandate if we are not sure we can control costs? So, what we do is, all right, let us put in the cost controls first. And on our proposal, we phase in small business. They have a 3-year phase in, both new and small businesses.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Magowan, I applaud you for getting involved in the health care debate while running a pretty big corporation full time. I suspect you found it more complicated, more time-consuming, and more difficult than when you started—at least, that has been our experience on this committee.

According to your written statement, nearly one-third of your employees are overseas—that's a very hefty number of employees. Of 110,000 employees with 78,000 in the United States, the balance, I assume, is overseas.

Mr. MAGOWAN. They are in Canada.

Senator CHAFEE. In Canada. It seems to me, I saw one of your stores in Great Britain. Could that be right?

Mr. MAGOWAN. When did you see it? [Laughter.]

Senator CHAFEE. Well, I will have to acknowledge——

Mr. MAGOWAN. We sold our stores in 1986 to the Argyle Corporation.

Senator CHAFEE. Oh, did you?

Mr. MAGOWAN. They are the third-largest food retailer in the U.K. But they did retain the name Safeway.

Senator CHAFEE. I see. Well, I take very few trips overseas as a Senator, so I——[Laughter.]

It was a long time ago that I was there. Now, it seems to me—and no one can argue with the points you've made. We have considered those points in various proposals that have come before this committee: malpractice reform, insurance reform, and reduction of administrative costs.

The heart of your proposal, as I see it, is cost containment and bringing down the rate of growth. And, if I am plowing old ground here, forgive me. I arrived a little bit late.

Now, if we assume that last year the total health care costs in the United States were $800 million—just to take a figure—and that the cost of health care has been going up at the rate of 12 percent a year, you are proposing not to continue increasing costs at the rate of 12 percent a year, but rather, increase cost at the rate of 10 percent a year until you get to the CPI.

Mr. MAGOWAN. Correct.

Senator CHAFEE. Now, in order to do that, as I understand it, you'll create a bureau. Is that the correct word for it?

Mr. MAGOWAN. Commission.

Senator CHAFEE. Commission. All right. Now, how do they do it? What do they say to Rhode Island Hospital? How are you going to keep your costs down for somebody who is not on Medicaid, not on Medicare, but is a Safeway employee who is going in for an appendectomy? Anyone in the group can respond.

Mr. MAGOWAN. Well, let me just try to tackle your question, first, and then I think Dr.——

Senator CHAFEE. Let us just say that the operation has been $1,000. How are you going to lower costs by 2 percent?

Mr. MAGOWAN. We thought that the best thing to do, rather than to tell them in every specific detail how to do it, was to set the overall target and say, in this place you guys might figure out how to do it this way, another place might figure out a different way to do it. There are many places to look.

If you could argue that 20–30 percent of all procedures that are done in the country do not have to be done, then maybe the local hospital, or whatever, would say, we could cut down on the frequency of all of these procedures.

If one particular hospital keeps it patients, on average, 2 days more than another particular hospital does and they are made aware of these facts, they might take a look at how long people stay in the hospitals.

But we thought, rather than tell them specifically how to cut costs in each area, better to set a broad, overall target—there are many ways to get there—and let the individual, local board determine the details of it.

Senator CHAFEE. When you say "local board," what do you mean? Do you mean a local board of the hospital, or some governmental——

Mr. MAGOWAN. No. State.

Dr. SIMMONS. Senator, basically it would work very much the way the Congress has now currently designed the way it is going

to handle Medicare costs in escalation. And Rhode Island would be basically subject to a DRG and an RBRVS with a conversion factor.

That conversion factor, determined by the level of total health care services this board has set, 2 percent less each year until it reaches the GDP. So, it is very similar to the way you have begun to operate the Medicare program.

Now, the option would be for Rhode Island to seek a waiver from that and set up its own mechanism, as long as it met the expenditure target, which is allocated to the State of Rhode Island from the national pool.

And that is fundamentally how it would work. And that is the way it works, as I said, both in rate-setting States, here, in Canada, and in several other nations.

Senator CHAFEE. Well, obviously, in my judgment, this is the heart of your proposal.

Dr. SIMMONS. Well, Senator, actually, in our judgment, it is not the heart of our proposal. There is no particular—we think every one of those eight elements is important.

And, in fact, if you sat in our coalition meeting, I believe the coalition members would say the heart of the proposal is the quality and efficiency piece, without which we do not know how to contain costs.

I believe you would get almost a unanimous judgment on that, but, certainly, the cost containment is extremely critical, but no more critical than the quality initiative.

Frankly, we are a little discouraged that that has not received the attention that it needs nationally. Mr. Magowan, himself, is deeply concerned about that.

Senator CHAFEE. Well, my time is up. But let me just say, it is our belief, generally, that the quality of care—I notice your three points—has not been a problem; but that does not mean that we should not work on improving quality. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. I am curious, gentlemen, under your system or any system, if there is some basic reason why health care expenditures should go up at a rate faster than the CPI. Is there anything endemic to health care that means it should be higher or lower than CPI, or at CPI?

Mr. MAGOWAN. I think there are a lot of things that have caused it to go up higher than the rate——

Senator BAUCUS. No. I am not talking about in the past. We know what the past causes are. I am wondering about this plan that you have. Are there any reasons why, or pressures to cause health care to go up greater than CPI?

Mr. MAGOWAN. I think there is a lot of pressures that are going to cause it to go up greater than the CPI in the future. We have got demographic changes that are very important.

Our Nation is aging. We are capable of prolonging life in a way that was not possible before. There is a lot of new, exciting, but very expensive technology and equipment that is being more and more utilized.

Senator BAUCUS. But your proposal, though—I am sorry, I do not sufficiently understand it—that health care expenditures under this commission would be capped at CPI?

Mr. MAGOWAN. No.

Dr. SIMMONS. No, Senator. Senator, basically where we started was this. You asked the fundamental and critical question: how much should any society spend? How much do we, as a society, want to spend? We asked ourselves the same question. We did not come to an answer, 10, 12, 15 percent.

But what we said was this: it does not seem to us that we can defend whatever we are spending currently on health care, given the amount of waste that we see in the system when other nations run universal access at half, to two-thirds our cost.

So, we said, all right, let us at least cut it back to the rate of growth of our total economy the way other nations have done. And we can get there, in our judgment, without hurting people.

Senator BAUCUS. So, you do say that regardless of the pressures that health care expenditures may have which increase health care expenditures at a rate faster than CPI, regardless of all that, you want to set up a system where health care increases are no more than the CPI in the future. Is that right?

Dr. SIMMONS. Over 8 years.

Senator BAUCUS. Over 8 years. Over an 8-year period they are going to get to the CPI, period.

Mr. MAGOWAN. Correct.

Senator BAUCUS. All right.

Mr. MAGOWAN. As other nations have done.

Senator BAUCUS. All right.

Dr. SIMMONS. And then we will say the judgment will be as a society, and, obviously, ultimately at the will of the Congress and the President, do we spend more or less than that it the future. And that is a societal decision.

Senator BAUCUS. All right. Now, I am sorry. So I understand this proposal a little better, how does this commission set health care limits? In my State of Montana, St. Vincent's Hospital in Billings, MT. Let us say that 8 years from now the commission sets a cap, I guess, on health care expenditures overall, but let us say to hospitals. What happens if St. Vincent's charges more than it has been proportionately charging?

Dr. SIMMONS. Well, basically it is the same as the answer I just gave to Senator Chafee. It is the same way that your hospital would react under the Medicare program if they spend more than the DRG allocation. They have to figure out a way to get compensation for that.

Senator BAUCUS. Then you are saying that essentially the DRG system would apply to all patients?

Dr. SIMMONS. Well, that is one option that the Congress could adopt.

Senator BAUCUS. What are you proposing?

Dr. SIMMONS. We did not propose whether it would be a DRG or some other mechanism.

Senator BAUCUS. What are you proposing?

Dr. SIMMONS. We said there has to be that kind of a mechanism. We did not say the mechanism. We said there has to be a fee schedule, there has to be some allocation of the total budget, and, from that, an all-payer rate-setting mechanism.

Senator BAUCUS. Does this commission, then, engage in global budgeting per hospital?

Dr. SIMMONS. Yes. Global expenditure target.

Senator BAUCUS. Per hospital?

Dr. SIMMONS. No, it does not.

Senator BAUCUS. Then what happens if it is a target—by target you mean overall for the Nation?

Dr. SIMMONS. Yes. A global expenditure target for all spending, Federal and private.

Senator BAUCUS. And, again, what happens if one hospital charges more? I do not understand this, frankly.

Dr. SIMMONS. Well, it is the same way that you are currently operating the Medicare program and the way hospitals are run.

Senator BAUCUS. But there is cost-shifting to Medicare. That is how hospitals get around it.

Dr. SIMMONS. Right. And that would be eliminated under our program. You would have to learn to deliver care at a level that society has to pay you. It would force that kind of efficiencies in the system.

Senator BAUCUS. But I still do not understand how you deal with the hospital that charges a lot more than it has proportionately been charging if the only cap is a total national cap.

Dr. SIMMONS. Well, it is a total expenditure target nationally that is allocated on a per capita basis to each State that is coupled with a rate-setting mechanism that meets that target. It is the same way you have designed the RBRVS right now in that you are implementing in the country.

Senator BAUCUS. Oh, I see. So, it is a per capita allocation.

Dr. SIMMONS. Yes. The allocation.

Senator BAUCUS. It is per capita. I see. So, what do you do about outliers? Let us say some hospital suddenly gets a whole rash of AIDS cases or something and it just has big, heavy expenditures?

Dr. SIMMONS. Well, obviously the system has got to be designed to be sensitive to those kind of aberrations. Frankly, Senator, we did not get into that level of detail. We are up at a higher level, and Senator Chafee has asked a very important detail question, as have you. Frankly, we did not get into that level of detail.

Senator BAUCUS. Yes. See, the problem is, the Devil is in the details here.

Dr. SIMMONS. Oh, sure. But until you agree on the basic structure, you cannot even get to the detail.

Senator BAUCUS. Yes. I appreciate that. But I think you also have to know the details, as well as the structure, before you implement anything.

Dr. SIMMONS. Absolutely. Before legislation.

Senator BAUCUS. Because otherwise we are going to get ourselves, I think, in a lot of trouble.

Dr. SIMMONS. Sure.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Hatch, for any comments you might have.

Senator HATCH. I am delighted to welcome you here and am interested in your proposal. I like most of the eight elements of the coalition's plan to control costs.

One of the problems with the current play-or-pay program, which I have referred to as the Mitchell-Kennedy mandate, is that they do an awful lot about imposing the play-or-pay mandate but do not do much about controlling costs.

For instance, you provide for malpractice reform, or what I call medical liability reform, and you call for national practice guidelines, which I think is quite similar to what I have been talking about; getting a system where everybody knows what you work in, and if you meet those guidelines you have an automatic defense that you could easily raise in a malpractice suit.

Do you have any indication, Doctor, or any of your testifying here today, what you think the direct and indirect costs are of defensive medicine caused because of the fear of medical providers, and doctors, and practitioners that they might be sued for medical liability?

Mr. MAGOWAN. I think it said that 10 percent of all costs are because of malpractice.

Senator HATCH. Now, I not talking about because of malpractice. I am talking because of the fear.

Dr. SIMMONS. Defensive medicine.

Senator HATCH. Defensive medicine.

Mr. MAGOWAN. Oh. Well, then the other part of it is that 20–30 percent of all procedures done in the country, we estimate, do not need to be done. And the main reason why we have that level of excessive procedures is the threat of malpractice law suits.

Senator HATCH. It has been estimated anywhere from $20 billion a year to $200 billion a year are unnecessary costs driven by the fear of doctors and medical care providers that they might be sued for medical liability. You do not disagree with that range?

Mr. MAGOWAN. I think it could be low.

Senator HATCH. In other words, it could be higher than $200 billion a year?

Mr. MAGOWAN. Well, no. Twenty to 30 percent.

Senator HATCH. Well, 30 percent of $817 billion is $240 some billion.

Mr. MAGOWAN. Yes.

Senator HATCH. Now, I agree with you. I think it is in the upper limit, and if we could save just a fraction of that it would help. So, you have that provided for, and some of your ideas are generalized in your statement, but, still, I commend you for them.

When you talk about the payroll tax rate that these small businesses are going to have to pay, which I understand by your bill you would phase in, you would phase in their obligation over a 3-year period.

Mr. MAGOWAN. Correct.

Senator HATCH. Now, some small businesses will not be able to pay, no matter what. The average small business only earns about $30,000 gross income per employee. So, there is not a lot of margin to pay this 45 percent medical care that you cite in your statement.

But let us assume they can. What would be the percentage they would have to pay if they did not play by providing insurance for their employees?

Mr. MAGOWAN. It is 7 percent.

Senator HATCH. You think 7 percent would cover their costs of paying into this, what I call Federal health welfare system?

Mr. MAGOWAN. It might not fully cover their costs, but I think everybody assumes that there will be some subsidy of these smaller businesses in the rate mechanism. It cannot be so much of a subsidy that everybody wants to jump into it.

So, we have estimated that to keep it at this ratio of 3 to 1 between what is provided by the private sector to the public sector, it would be at about 7 percent.

And we think that small businesses now not providing insurance would take advantage of that 7 percent, rather than set up their own insurance system.

Dr. SIMMONS. Senator, under our proposal there is a substantial subsidy built in to small business deliberately, and that comes from the .5 percent payroll tax up to Social Security max, levied against every American above 200 percent of poverty, and every employer.

The bulk of the payment for those who are uninsured and below poverty comes from that pool, but some of it also comes from that 1.75 percent that is in our play-or-pay proposal, which was the figure that actuarily we calculated——

Senator HATCH. That is a more intelligent approach than what we have been talking about in the Senate. Because basically what you are saying is that there will be subsidization because right now it is costing 12–13 percent to meet the needs of health care.

Dr. SIMMONS. Yes.

Senator HATCH. And small business makes up almost 50 percent of the total employment in this country.

Dr. SIMMONS. That is why we deliberately designed it. In fact, that is the genesis of a pay-or-play proposal, to soften the impact and to give a subsidy to small business so they could, in fact, participate in coverage.

Senator HATCH. You see, I am concerned even with the 7 percent that many small businesses will not be able to play.

Mr. MAGOWAN. Ninety percent of them, though, now do provide insurance. As the Chairman said, maybe not as full insurance as everybody, but 90 percent of them do provide insurance.

Senator HATCH. That is right. That is true. But that does not necessarily make it possible for them to continue in business if the 7 percent is more than they can pay. That is my point.

Mr. MAGOWAN. Right. But our hope would be that the systems that we have will be able to drive down costs over a period of time, much less than what they now are which will make it more attractive to them, because they are very scared of the rate of increase and the uncertainty of that increase.

Senator HATCH. I understand that. Now, your plan counts on DRG's and RBRV's to control costs. And you stated a bit earlier that Medicare expenditures have not been cut, but that the rate of growth of Medicare expenditures has been reduced. Are you considering the increase in Medicaid beneficiary costs as well as Part A and Part B when you make that statement? And could you provide us with your analysis so we can look that over?

Dr. SIMMONS. Yes, Senator. When we calculated the total cost of implementing our universal access—$34 billion—we factored in there the amount that would be taken to raise Medicaid to a more

reasonable pay structure, up to the Medicare level. And that is the in the last page of our report. That chart is there, but we will provide it for the record, also.

Senator HATCH. If you would, we would appreciate it because I am very intrigued with some of the things you are saying. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. I apologize for being late. Mr. Magowan, you run a very large business, which you have some employees, presumably, at the relatively lower end of the pay scale.

Now, what Mr. Hatch wants us to believe, and others, is that it is all right for you to say that because you are a big company, but a small company cannot say that because a small company is not going to have the margin that you do. You say 90 percent provide already. That is higher than I would have guessed, but, nevertheless, people generally want to provide health insurance to their workers.

What those who oppose all of this say it is going to put everybody out of business. It is going to put hundreds of thousands, or a quarter of million, out of business.

So, there has to be some way in which we are able to convince small business that this will work for them, or, that in the course of marking this process up, we will make it work for them.

And in that, it seems to me, comes the explosive issue of cost containment. I want you to address that in terms of how cost containment, in fact, would help a small business, and any other argument you would use to small business to say, one, this can work; two, the way we are going is not a disaster.

Mr. MAGOWAN. First of all, Senator, our company is not a low wage rate employer. The average wage in our company, including benefits, is almost $15 an hour.

Senator ROCKEFELLER. Well, then mark me down for wrong analysis. [Laughter.]

Mr. MAGOWAN. Well, I would say to small business, the hope would be that these reforms are going to get America into a much more competitive condition so that we can compete more effectively in the world.

Senator ROCKEFELLER. Now, that works, but it does not work so well with small business. You see, I am worried about Mr. Hatch's people who are not exporting to Korea. These people are the corner of the block in Ogden, Utah and they are trying to make a go of it. Now, it is these folks that you need to address. What do you say?

Mr. MAGOWAN. All right. Take a look at Hawaii. Hawaii has got a lot of small business.

Senator ROCKEFELLER. No, I do not want to use Hawaii. Hawaii is surrounded by oceans, it does not have much alternative. Ogden, UT. Ogden, Utah.

Mr. MAGOWAN. Ogden, Utah.

Senator ROCKEFELLER. That is what we want to talk about. [Laughter.]

And talk about cost containment. I am just trying to throw out the fattest snowball I can.

Dr. SIMMONS. Well, I would like to try that, Senator.

Senator ROCKEFELLER. All right.

Dr. SIMMONS. I think the best thing that could happen to small business in Ogden, Utah, or anyplace else would be the adoption of a program like this.

Because right now, as Mr. Magowan said, 95 percent of large or small businesses do provide coverage. They are getting stuck with these escalations you know about, and those escalations would cease under this program.

So, one, the cost containment provisions would help very substantially small business.

Senator ROCKEFELLER. Explain that, how they would help.

Dr. SIMMONS. Well, because their premiums would not continue to increase at 20, 40, 50 percent a year. That is a thing of the past with this ratcheting down that we are talking about. And then, of course, the subsidy built into a proposal such as ours is substantial for small business.

It would be, we calculate, deliberately structured so that lower wage firms would probably find it less expensive to arrange their care under this proposal, the public sponsor, than to buy it in the open market. That is a deliberate design feature.

Mr. MAGOWAN. The insurance reforms we have proposed are directly designed to help small business. Right now, the small businesses pay considerably more than big businesses in the same geographic area. Under our proposals, those differences would be eliminated.

Dr. SIMMONS. The elimination of medical underwriting, the inability to renew because of one bad claim.

Senator ROCKEFELLER. And, in fact, you community rate, do you not?

Dr. SIMMONS. Yes.

Senator ROCKEFELLER. You community rate insurance, whereas the so-called Mitchell plan has a 1.3 band margin.

Dr. SIMMONS. Right.

Senator ROCKEFELLER. So your insurance would be even stronger.

Dr. SIMMONS. Right. Yes.

Senator ROCKEFELLER. So, the question is, are there any more arguments you would bring to the table for small business?

Dr. SIMMONS. Well, first of all, the insurance reform, as Mr. Magowan said, is very important. The elimination of medical underwriting, the community rating, the inability to raise premiums on the basis of one bad risk; that is very important.

The cost containment features we talked about: administrative simplification, which cuts the total cost of care. The whole quality thing. Senator Hatch, in response to your question, those are all cost containment mechanisms, it is not just the three. Your malpractice reform is a cost containment mechanism.

Senator HATCH. No, no. I got that.

Dr. SIMMONS. Defensive medicine.

Mr. MAGOWAN. The small businesses that are providing insurance now are subsidizing the small businesses that are not.

And the small businesses that are not providing insurance now at least would all be on the same boat if their competitors, many

of whom are also in small business, had to face a cost increase in the first year or so while this was being implemented.

Senator ROCKEFELLER. And you would say, would you not, to small business, in order to get them on board—which is very important; they have a lot of leverage, they tend to like that—that you would provide, in fact, subsidies in the mark-up were you in our position, if this was something that was required.

Mr. MAGOWAN. Under our proposals they are starting off being subsidized. And if that would not be enough to get them to participate, if that seven percent rate was inadequate, I think our figures are not cast in stone.

We are also letting them phase in over a 3-year period of time, so they are not suddenly faced with a large increase that they have not been able to prepare for.

Senator ROCKEFELLER. And you can see that going to 5 years, if insurance reform were likely to take longer, et cetera. You would be flexible.

Mr. MAGOWAN. Yes.

Senator ROCKEFELLER. So, small business needs to understand that this is an open table that we are all negotiating at.

Mr. MAGOWAN. Exactly right. I mean, we had to come up with some figures to put our proposals together, but they are flexible.

Senator ROCKEFELLER. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Let me say, we have other panels here, of course. But I want to make one comment, Mr. Magowan, because your 90-percent figure keeps disturbing me. When you tell me that small business provides health insurance, 90 percent of them, I really do not buy that.

Let me give you some numbers. These are the CRS numbers. And, of course, the likelihood that health insurance is offered increases substantially with the number of employees in a business.

But this is what the 1989 survey shows by the Health Insurance Association of America: 26 percent of firms with fewer than five employees offered health benefits; 26 percent.

And I will tell you what else I will bet you. I will bet you that very few of them covered the dependents, and they had a high deductible, and maybe co-insurance.

Now, that compares to 54 percent for firms with 5 to 9 employees; 72 percent for firms with 10 to 24; 90 percent for firms with 25 to 49; and 97 percent for firms with 50 to 99, and 99 percent with firms with 100 or more. Of the employed uninsured, 50 percent work for firms with fewer than 25 employees.

So, when you get to really small businesses, you have very little insurance and that tends to be is modest coverage, indeed. That is part of the problem we face. Thank you very much, gentlemen. We are appreciative of having you. It has been helpful.

Now we will have Mr. Bernard Tresnowski, who is the president of Blue Cross and Blue Shield Association. Well, Mr. Tresnowski, we are delighted to have you back, and are looking forward to your testimony.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, CHICAGO, IL

Mr. TRESNOWSKI. Thank you, Mr. Chairman. I would appreciate it if you would take my full statement and introduce it into the record.

The CHAIRMAN. That will be done.

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

Mr. TRESNOWSKI. I will summarize. I am here today for one reason, to talk about how we can break the gridlock in the health care reform debate.

The Blue Cross and Blue Shield Association believes that the health care status quo no longer is acceptable. We acknowledge that insurers need to clean up their own act. All the stakeholders in reform need to make sacrifices if we are to reach a compromise.

Our alternative, which we call Community Partnerships for a Healthy America, blends an employer-based coverage mechanism with government subsidies to expand access for working and nonworking Americans alike. It begins in the work place where most Americans already get their health insurance.

Most people like that arrangement, so let us start with that base, fix the problems, and use it to extend health insurance to as many Americans as possible.

We believe our proposal for reform constitutes a thoughtful, innovative alternative to the two basic strategies for employer-based coverage. That is, an across-the-board employer mandate, and a play-or-pay strategy, the most common plan to broaden access through the workplace.

Other employment-based approaches have a key severe flaw: they make unrealistic assumptions about how much small employers can afford to contribute to health benefit costs.

Our plan would reform the system to make coverage universal and portable between jobs, and it would do so without the high taxes or bureaucracy needed for a single-payer system.

It provides flexibility to add or change benefits to meet the needs of employees, rather than having benefits determined by the political process.

Our proposal recognizes that we cannot treat large and small employers the same way. Just as most of them do now, large employers would be required to contribute to employee coverage.

Small employers could contribute to premium costs, or they could decide only to offer, not pay for the coverage. Employees of small employers would receive subsidies to help pay the premiums.

The Blue Cross and Blue Shield Association, however, fundamentally believes that universal access to health care hinges on health care cost containment.

We further believe that the only viable avenue to cost control is to establish a system that encourages better medical practice and health care delivery systems that are more efficient and responsive to community health care needs.

This approach relies on reforming and continuously improving delivery systems in every community in this country.

Our experience indicates that the techniques collectively known as managed care can make health care more affordable. But man-

aged care, operating in the current health care financing market, is still a long way from offering an effective cost containment strategy.

We must move into a new generation of managed care. Just as management techniques have been sharpened in other sectors of our economy, similar improvements must be achieved in health care financing and delivery.

I have not come here today as a defender of the status quo, to ask you to leave things alone. Instead, we need to apply an aggressive, comprehensive health care reform strategy based on the promising beginnings we see in managed care. We have to rebuild the current system from the ground up.

Mr. Chairman, we are talking about a new way of doing business, but we believe it is a way of doing business that can work to the benefit of all Americans. Thank you very much. [Pause.]

Well, as I understand, you made a much more limited statement than I would have preferred. [Laughter.]

Mr. TRESNOWSKI. I thought I left you speechless.

The CHAIRMAN. I would like to know a little more of the details. As my friend says, the Devil is in the details. So, I would like a little more differentiation than what I have heard thus far as to why your system is better. You obviously do not think managed care alone, from what I heard, is going to stop the increase in the cost of growth. Is that correct?

Mr. TRESNOWSKI. No. I said I think we need to give managed care a chance to work. People have been critical of managed care.

The CHAIRMAN. Well, I understood that. But that, by itself, as I gathered it from you, would not be sufficient. Is that correct?

Mr. TRESNOWSKI. No, I am not saying that.

The CHAIRMAN. Well, you see, that is why I need more of the details of what you have got.

Mr. TRESNOWSKI. All right. Let me deal with it in two parts. First, let me refer back to Senator Packwood's comments earlier this morning when he talked about his CHIP program which requires an employer mandate.

We have looked at the straight employer mandate; we have also looked at the play-or-pay proposal. What we are suggesting on the financing side is a blend of the two proposals.

What we are saying is, let us ask large employers to continue to do just what they have been doing in this country: paying 80 percent of the premium for their workers; 50 percent of the premium for their dependents. We believe large employers should continue to do that. If you want to call it a mandate, call it a mandate.

For the small employer, let us ask the small employer, because they are different, to offer a group health benefit program, provide for payroll deduction and negotiate with an effective health care carrier. If that small employer wants to contribute to premiums the way a large employer does, so be it. But we would not require a small employer to contribute.

If they do not, what we are saying is, ask them to pay a 3 percent payroll tax. If you will, a modified pay-or-play, and then rechannel that money back to subsidize the premiums. That is the financing piece.

The CHAIRMAN. Yes. I heard that.

Mr. TRESNOWSKI. Next, in terms of cost containment, we need to build an infrastructure of what we called accountable health plans in this country.

These are insurers that are operating at the community level that compete not on the basis of their ability to select risk, but rather on their ability and commitment to managing health care costs at the community level. We view this as a second generation of managed care.

It is a commitment by that insurance carrier to use techniques of information technology to profile physician practices, to understand what hospitals do in terms of delivering quality care, and to effect changes in the way health care is delivered.

Now, will that solve the problem of the escalation of health care costs? I do not know. I cannot sit here today and honestly tell you that it will. But I want to tell you that if you put a global cap in place today, without building an infrastructure that effects care at the community level, then you are going to be making a large mistake.

The CHAIRMAN. Bernie, let me understand again, because you have just skimmed over the top of this. Are you saying that the insurer, because of what they will pay for, that they are beginning to be the cost containment apparatus for the providers in the regional areas?

Mr. TRESNOWSKI. Absolutely. That is right.

The CHAIRMAN. Is that what you are saying?

Mr. TRESNOWSKI. That is exactly what I am saying. What you need to do, Mr. Chairman, is change the way health care is delivered at the community level. That is the only way we are going to deal with the cost problem in this country.

And in order to do that, you need to change the incentives that drive the system: the incentives that drive the physician practice, the incentives that drive the hospital, indeed, the incentives that drive the consumer. And what we mean by incentives is how you pay.

The CHAIRMAN. All right. I understand that. But, then, is there a competition between the insurers, amongst the insurers insofar as selling this plan to the employer? Is that what you are saying?

Mr. TRESNOWSKI. That is right.

The CHAIRMAN. And the competition is through not only the premium and what you will offer the coverage for, but how far that coverage goes in the way of compensation, what it does cover.

Mr. TRESNOWSKI. That is right.

The CHAIRMAN. Is that correct?

Mr. TRESNOWSKI. That is right. It is two things. It is the premium you charge which is a reflection of your ability to manage the health care costs, and, secondly, the efficiency with which you do your job.

The CHAIRMAN. Well, not just how efficiently you manage it, but maybe what your coverage is.

Mr. TRESNOWSKI. Well, the coverage is defined. You define a basic set of benefits under our proposal.

The CHAIRMAN. Who does that?

Mr. TRESNOWSKI. What is it?

The CHAIRMAN. Who defines the basic set of benefits?

Mr. TRESNOWSKI. You do. You do, in Federal law.

The CHAIRMAN. The government. All right.

Mr. TRESNOWSKI. Yes. You define what that is.

The CHAIRMAN. All right.

Mr. TRESNOWSKI. You can do it by saying you want primary care in the physician's office, you want hospital care, you want preventive services. You can then cost out an actuarial equivalent of that and then make that the amount.

The CHAIRMAN. I see. Now, what about above that? Suppose I do not want just the basic benefits for my employees, and I want something a bit more generous. What do we do about that?

Mr. TRESNOWSKI. Carriers would be allowed to offer other packages. However, under our proposal amounts above that limit would not be tax exempt for the employee.

The CHAIRMAN. Well, that gets his attention.

Mr. TRESNOWSKI. Well, what it does is——

The CHAIRMAN. And what that does, of course, that makes that employer or that employee feel it and maybe they become a little more market-conscious of the costs.

Mr. TRESNOWSKI. That is right. That is right.

The CHAIRMAN. That is what you are driving at, is it not?

Mr. TRESNOWSKI. Exactly.

The CHAIRMAN. Yes. All right. Senator Packwood.

Senator PACKWOOD. That last one that you just slipped by there.

Mr. TRESNOWSKI. I thought I would catch your attention on that one, Senator.

Senator PACKWOOD. Not tax deductible to the employer, and it will be counted as income to the employee, both. Is that correct?

Mr. TRESNOWSKI. Yes, that is right.

Senator PACKWOOD. You have got a double enforcement mechanism.

Mr. TRESNOWSKI. Well, the idea here is to serve as an incentive for the employer to use these accountable health plans or these insurers at the community level.

Senator PACKWOOD. I think I understand what you are saying. Forget this part. That part is easy to understand. You are going to have the Federal Government set, by statute, a basic level of care. And then the enforcement will come in the competition between insurers.

Mr. TRESNOWSKI. That is right.

Senator PACKWOOD. This is a direct descendent of Dr. Enthoven's managed competition idea where you set a basic benefit level and then the competition comes between those who will provide it.

Mr. TRESNOWSKI. That is correct. As a matter of fact, there is a very good model of this. In fact, it was drawn up in this committee, passed in the Congress, and signed by the President in 1990. It was the Medigap law where you defined the benefits.

Senator PACKWOOD. Yes.

Mr. TRESNOWSKI. You delegate it to the National Association of Insurance Commissioners, the Development of Model Acts, the State Insurance Departments have implemented them. You have got an oversight responsibility in the Health Care Financing Administration. And, do you know what? It works. That is the model.

Senator PACKWOOD. In one of the places—it is not a significant difference—where you differ from my comprehensive insurance plan is you use some of this payroll tax for subsidy, but you purchase that insurance privately. You do not go into a public plan.

Mr. TRESNOWSKI. That is correct. Precisely.

Senator PACKWOOD. I have no other questions. I understand it very well. I think, by and large, it has got much merit.

The CHAIRMAN. An interesting proposal. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman. You have distinguished your proposal from the pay-or-play plans. But, if I understand your plan correctly, it is basically similar in one very important aspect, is it not?

And that is, that small employers who do not contribute to the costs of their employee's insurance would face an assessment. Is the difference on this point not that the small employer would pay a smaller assessment in your plan than what other plans require?

Mr. TRESNOWSKI. Yes. It is the difference between 9 percent and 3 percent, or, in the Leadership Coalition, 7 percent/three percent.

Senator GRASSLEY. Your plan does rely heavily on subsidies, if I understand you correctly.

Mr. TRESNOWSKI. That is correct, Senator.

Senator GRASSLEY. All right. Would all of the subsidy that you envision go directly to the employee? How would that work? I guess some sort of elaboration on how you anticipate that coming out.

Mr. TRESNOWSKI. Well, there are a variety of possibilities: vouchers, refundable tax credits. There are a number of approaches that could be applied to achieve the subsidy.

Senator GRASSLEY. So, is it your point to leave it very flexible, or is it your point that you have not thought that out entirely yet?

Mr. TRESNOWSKI. No. No. As a matter of fact, we think that the subsidies are very clear. I think the objective is to make sure that every American has the wherewithal to purchase private health insurance, and the subsidy would accomplish that.

Senator GRASSLEY. Would the 3 percent assessment on small firms which do not contribute directly to their employees' health insurance go to the Federal Government?

Mr. TRESNOWSKI. Yes. It would go to the Federal Government to be used to help finance the subsidies that would flow back to the individuals. The subsidy would finance 40 percent of the premium in the small group, and over and above that, based upon income level, it would finance 50, 60, or even 100 percent if they were below 200 percent of poverty.

Senator GRASSLEY. Do you have any sort of idea of what the subsidy would cost?

Mr. TRESNOWSKI. We do not, to be honest with you. We are still working with a group of economists to help us estimate the costs.

Senator GRASSLEY. Mr. Chairman, I have no further questions.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Mr. Tresnowski, frankly, my position is, I would rather take anything, either play-or-pay, or, for that matter, single-payer, over what we have now, just to sort of establish where I am coming from.

I think where we are now is so damaging and so bad, and folks who are not walking up to the table on this are, in a sense, damag-

ing themselves. I am not saying you are doing that, but I just want to establish where I am coming from.

I set my criteria for coverage for everyone, because anything else means cost-shifting. Anything else means cost-shifting and cost containment. And, when I say cost containment, I mean really tough cost containment.

Now, I just want to push you on yours. The Wall Street Journal had an article the other day about a family that wanted health insurance but could not afford it. Since you do not require employers to purchase health insurance for their employees, you sort of nudge them, but you do not require them to do it. And, therefore, in a sense, you leave it up to the employee. Stop me if I am misstating.

Mr. TRESNOWSKI. Well, first of all, let me clarify that it is the small employer that that would apply to. Large employers would be mandated to provide the health coverage.

Senator ROCKEFELLER. Yes. But I mean the small employers is where our argument is.

Mr. TRESNOWSKI. Yes, small employers. And they would pay the 3-percent tax which would be rechanneled to finance 40 percent of the premium.

Senator ROCKEFELLER. Yes. So, but remember my first premise is universal coverage.

Mr. TRESNOWSKI. Right.

Senator ROCKEFELLER. All right. So, you leave it up to the employees. What happens to people who, under the American rules, they work hard, they play by the rules, they work every day, but they do not qualify for medical help because their company does not offer it, they do not have enough money to go out and buy it on their own, and they have got to pay mortgages and other living expenses. Now, what happens to these people under your plan?

Mr. TRESNOWSKI. Well, what we have done is required the small employers to offer a group health benefit program. They have to offer it. They have to go out in the marketplace and pick one—hopefully Blue Cross/Blue Shield. They select a carrier for their employees and set up an insurance program.

They then provide a payroll deduction for that employee, so that the vehicle is in place. Now you get to the financing. What we are saying is that if the small employer chooses to finance it like the large employer, good.

If they decide not to, they pay a 3 percent tax. They pay instead of play. That money is rechanneled and pays for 40 percent of the premium of that health benefit plan that the employer has set up for their employees.

Senator ROCKEFELLER. And, thus, for that health beneficiary, pays 40 percent.

Mr. TRESNOWSKI. That is right.

Senator ROCKEFELLER. So that, as in Senator Packwood's plan, in a sense, or as in President Bush's plan, you are on the way. He happens to provide $3,750 tax credit that runs out at 150 percent of poverty, but it is on the way. Yours does not get to full coverage. I am not trying to shame you, I am just simply trying to get you to say you do not provide full coverage.

Mr. TRESNOWSKI. No, that is right. That is correct. Unless the individual is of an income level that would qualify for a full subsidy.

Senator ROCKEFELLER. In other words, 100 percent of poverty or less?

Mr. TRESNOWSKI. 200 percent.

Senator ROCKEFELLER. 200 percent. Is that sliding scale, 100–200 percent?

Mr. TRESNOWSKI. Yes. 200 percent of poverty would be 100 percent contribution to the premium.

Senator ROCKEFELLER. All right. So, minus the 200 percent and below, and minus those who, together with the 40 percent, can go out, take on the private market, and buy health insurance, those who remain would have to find coverage.

Mr. TRESNOWSKI. No, they would not find it, it would be there. They would just contribute to it.

Senator ROCKEFELLER. Well, they would have to be able to afford and get coverage.

Mr. TRESNOWSKI. Right. Right.

Senator ROCKEFELLER. All right. Now, the second key test, obviously, is cost containment. And it was interesting reading your testimony and then listening to some of your statements to Senator Bentsen. In your own words, you talked about a new strategy of managed care.

Mr. TRESNOWSKI. Right.

Senator ROCKEFELLER. Now, that is exciting.

Mr. TRESNOWSKI. Yes, it is.

Senator ROCKEFELLER. I do not know what it means.

Mr. TRESNOWSKI. I will tell you. [Laughter.]

Senator ROCKEFELLER. Then you talked about, let us change how health care is delivered in America.

Mr. TRESNOWSKI. That is right.

Senator ROCKEFELLER. And between these two things we are going to save so much money that we are going to have real cost containment. I want you to help me understand how this deal works.

Mr. TRESNOWSKI. Yes. I am not going to sit here and tell you, as the previous witnesses did, that there is going to be a 2 percent reduction in the rate of increase. I certainly hope that is true. What I am saying is we need to approach the change in the way health care is delivered at the community level. It just is not working.

Senator ROCKEFELLER. Well, give me examples. I am for that, too.

Mr. TRESNOWSKI. All right.

Senator ROCKEFELLER. Now, tell me. And when you say, we have got to, is that something we do in Congress?

Mr. TRESNOWSKI. Let me give you an example right here in the District of Columbia.

Senator ROCKEFELLER. Why is this not in your bill, the way we are going to do this?

Mr. TRESNOWSKI. It is. It is.

Senator ROCKEFELLER. All right. Go ahead.

Mr. TRESNOWSKI. There is a good example of managed care right here in the District of Columbia. Our D.C. plan profiled the practices of 7,000 physicians in the District. This data showed us remarkable differences of substantial dimension in the way health care is practiced.

After reviewing the physician practice pattern data, and consulting medical advice, we selected those physicians who practice medicine effectively and efficiently. Next, we developed our current network based on that data.

Now, that is an example of the application of information technology to trying to change the way medical practice is delivered.

Senator ROCKEFELLER. Outcomes research. You are talking about outcomes.

Mr. TRESNOWSKI. No. I am not talking about outcomes, I am talking about the way physicians practice. Outcomes is another dimension which I think holds great promise, but there you are talking about what happens to the patient. I am talking about how the doctor go about his business.

Senator ROCKEFELLER. Mr. Chairman, my time is out. I remain muddled. [Laughter.]

The CHAIRMAN. Well, apparently he is offering a pretty good package. I understand most of my staff is signed up with him. [Laughter.]

Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Two things that have surfaced as far as cost savings. One is so-called administrative costs. All we have to do is cut down the number of insurance companies' forms from 1,600 to one.

First, can that be done? Secondly, can managed care reduce costs? Could you amplify a little bit on that, as you started to? Are reductions in administrative costs feasible.

Mr. TRESNOWSKI. Well I just submitted an article to The New England Journal of Medicine answering that question. I will be glad to send it for the record, here.

Mr. TRESNOWSKI. But, in summary, what I have said is, if you take Blue Cross/Blue Shield, our administrative costs as a percent of revenue is 9 percent. If you subtract what we pay in taxes, it comes down to about 8 percent.

If you compare that on a percentage basis to what Medicare pays as a percentage we are very close. It is also important to recognize that Medicare's revenues, or its costs are higher because of the nature of the elderly population.

If you measure Medicare administrative costs on a per capita basis to us, they pay more in administrative expenses than we do. It is important that the numbers are viewed very carefully looked at.

So, having said that, there is an opportunity to save or administrative costs. I am co-chairing a committee appointed by Secretary Sullivan to apply information technology, Electronic Data Interchange.

We hope to report, by the middle of July, our recommendations on how the insurance industry could substantially improve their efficiency with the use of electronic, paperless processing.

Senator CHAFEE. All right. I am cutting you a little short here because that light is always a worry.

Mr. TRESNOWSKI. Sure.

Senator CHAFEE. To what percentage do you think administrative costs could be reduced? Could you then extrapolate that per-

centage into the dollar savings? Blue Cross is 9 percent. To what percentage do you think we could get overall for the country?

Mr. TRESNOWSKI. Well, I would not just pick on Blue Cross, I would take it across the board. I think we could save anywhere from $40–$50 billion if we were to go to electronic data processing.

Senator CHAFEE. All right. That is per year, obviously.

Mr. TRESNOWSKI. Yes.

Senator CHAFEE. Now, let us go to managed care and some of your thoughts on that.

Mr. TRESNOWSKI. Well, what I said is that the first generation of managed care was reasonably successful. We were able to demonstrate to the buyer a 10–15 percent differential in premium costs with managed care, as contrasted with indemnity coverage, for example.

That was a one-time savings, because it dealt mainly with preadmission certification, concurrent review—that sort of thing.

What we really need now is a more sophisticated approach—we call it "Second Generation Managed Care"—and it needs to drive at the fundamental way in which medical care is practiced and hospitals do their job.

This second generation approach is what I described here in the District of Columbia; we are also doing it in Minnesota, we are also doing it in Arizona, you are doing it in Rhode Island—it is an approach where the health insurance carrier negotiates and effectively changes the behavior of the way health care is delivered.

We perform small area variation studies, and then show the data to a doctor so that he realizes that his hernia rates are twice what they are in the next town. This process impacts his thinking.

Now, you have got to do that at the community level. You cannot sit in Washington, or you cannot sit in some distant area, you have got to do it where the action is taking place.

I happen to believe that doctors and hospitals want to do the right thing, but unless they are told and explained what the variation is, they are not going to know.

A case in point. In the State of Maine, they found that the prostatectomy rate in the State of Maine varied by 100 percent from city to city. Dr. Wennberg published those findings in the journal of the State medical society in Maine but took no other action. The next year, the rate of prostatectomies dropped 30 percent. And all he did was report it; he just reported it.

My point is that I think that medicine is as much an art as it is a science, and if you can impact it at the community level, there is opportunity to substantially change the cost picture.

Senator CHAFEE. Mr. Chairman, I think this witness has made a lot of interesting points. I am glad he testified, and I am glad we had a chance to hear his views. Thank you very much.

The CHAIRMAN. Well, I must say I am impressed, too. It looks like a hands-on approach that is beginning to reap some benefits.

Mr. TRESNOWSKI. Thank you, Mr. Chairman.

Senator CHAFEE. Everything you said about manage care would apply not only to physicians but would also apply to the hospital.

Mr. TRESNOWSKI. Absolutely.

Senator CHAFEE. I think that you will find that hospitals that are the most efficient in delivering a particular service, for exam-

ple, hernia operations, are efficient because of the volume of a particular service performed.

Mr. TRESNOWSKI. We put together a network on organ transplants of 73 institutions across the United States. We did it for our major accounts. The interesting thing we found was that there was a very high correlation between the costs, low costs, and the outcome and the result of the procedure. In other words, the higher the quality, the lower the cost in organ transplants.

Senator CHAFEE. Well, that is a winner all the way around.

Mr. TRESNOWSKI. Absolutely. It is a win-win situation.

Senator CHAFEE. We need more of that.

Mr. TRESNOWSKI. And that was not done through some arbitrary standard, it was done by looking at the precise way in which those institutions did organ transplants.

Senator CHAFEE. Well, that is what Dr. Enthoven has told us many, many times when he has appeared before the committee.

Mr. TRESNOWSKI. Yes.

The CHAIRMAN. Is part of that lower cost and greater efficiency because it is a more repetitive procedure in the institution?

Mr. TRESNOWSKI. Volume.

The CHAIRMAN. Volume.

Mr. TRESNOWSKI. Volume. Yes. The more you do it, the better you get.

The CHAIRMAN. Yes.

Mr. TRESNOWSKI. Yes.

The CHAIRMAN. At least, we hope so.

Mr. TRESNOWSKI. Yes.

The CHAIRMAN. Thank you very much.

Senator ROCKEFELLER. Oh, Mr. Chairman?

The CHAIRMAN. Oh, I beg your pardon.

Senator ROCKEFELLER. I am sorry, but I do not want Chairman Tresnowski here to leave feeling so incredibly good. [Laughter.]

The CHAIRMAN. I tried to get you out a little earlier.

Mr. TRESNOWSKI. I can always count on Senator Rockefeller to make my day.

Senator ROCKEFELLER. I have two points to make. You do agree, do you not, that what you are offering does not—except for people at the 200 percent and 40 percent factor, except as they are able to afford it—in and of itself require universal coverage?

Mr. TRESNOWSKI. That is right. For a small fraction of the population. Yes.

Senator ROCKEFELLER. And that cost-shifting, therefore, remains.

Mr. TRESNOWSKI. Yes.

Senator ROCKEFELLER. And the new strategy of managed care that you and I will have to talk about—I am teasing you in a sense because it is the kind of thing you can say, new strategies to managed care. Others will come in here and say, managed care is great, but it does not do it.

So, if I am in your position, I have got a new strategy for managed care. I am not sure what it is yet, but I am sure you are going to explain that to me.

But if you cannot, do you not agree with the proposition that when you are talking about physician behavior modification, when you are talking about outcomes research, when you are talking

about utilization review, when you are talking about all of those good things like malpractice reform that are going to happen tomorrow with 66 lawyers in the Senate blocking it every step of the way—not Chairman Bentsen and myself, but others—that you are talking about cost containment over a period of really quite a few years.

And my suggestion to you is that if it is true that the annual cost per employee, if we do nothing for health insurance coverage for the average business in America is going to be $22,000 by the year 2000, as some have suggested, that you really are banking a lot on behavior modification over a period of the next 7 to 8 years. I would question whether or not we have that time.

Mr. TRESNOWSKI. You said something earlier, though. You said that it is time to move. I agree with that. If we do not move, as I said in the opening of my statement, we are facing a medical melt-down in this country.

Senator ROCKEFELLER. Well, then answer my question.

Mr. TRESNOWSKI. What I am saying to you is if you think that in the next 5 years some magic bullet is going to solve the cost problem, it is not going to happen.

What I am suggesting is put in place an infrastructure, put it out there at the community level, and then let that play out. If it does not solve your problem, there are other strategies that can be employed. But do not ignore the opportunity to effect change at the community level. Put it in place. It is not there now.

Senator ROCKEFELLER. Empire came out yesterday for community rating. Any comments?

Mr. TRESNOWSKI. Well, they have always had community rating in New York.

Senator ROCKEFELLER. For every——

Mr. TRESNOWSKI. Blue Cross/Blue Shield has always used community rating in New York. As a result, we have been selected against. Now, the Governor has joined with Blue Cross/Blue Shield in support of community rating. But that is New York. It is a different situation in other parts of the country.

Senator ROCKEFELLER. I understand. Thank you.

Mr. TRESNOWSKI. Thank you.

The CHAIRMAN. Thank you very much.

Mr. TRESNOWSKI. Thank you.

The CHAIRMAN. Next is a panel consisting of Dr. William Custer, director of research, Employee Benefits Research Institute; Dr. Paul Griner, who is president-elect of the American College of Physicians; John Motley, the vice president for Federal Governmental Relations, the National Federation of Independent Businesses; Dr. Daniel Shea, president of the American Academy of Pediatrics; and Mr. John Sheils, vice president of Lewin-ICF, Fairfax, VA.

Gentlemen, I have some responsibilities on the floor, so I will turn it over to Senator Rockefeller to Chair. If you would proceed, Dr. Custer.

STATEMENT OF WILLIAM S. CUSTER, PH.D. DIRECTOR OF RESEARCH, EMPLOYEE BENEFITS RESEARCH INSTITUTE, WASHINGTON, DC

Dr. CUSTER. Thank you, Mr. Chairman and members of the committee. My name is Bill Custer. I am the director of research at the Employee Benefit Research Institute, a non-profit, non-partisan public policy research organization based here in Washington, DC.

Through our research, we strive to contribute to the formulation of effective health, welfare, and retirement policies. In keeping with EBRI's mission of providing objective and impartial analysis, our work does not contain recommendations.

Presently, 139 million Americans, 64 percent of those under the age of 65, receive health insurance through an employer or union-based plan. While the benefits enjoyed by these Americans provide them access to an ever-increasing range of health care services, the costs of these benefits are growing rapidly and are not distributed equally.

Spending on employer-sponsored health plans have tripled in the last decade, reaching $186 billion in 1990. Health spending as a percentage of total compensation increased by nearly 50 percent in the same period.

For employers that provide health benefits, those benefits averaged just under 11 percent of total compensation.

Senator ROCKEFELLER. Gentlemen, let me just get something straight here at the beginning. There are five of you. Are you all going to read?

I would like to sort of keep this to 5 minutes, because Senator Packwood, Senator Chafee and I would like to ask some questions, and you may want to debate amongst yourselves. Would you all agree to keep it within 5 minutes?

Dr. CUSTER. Absolutely.

Senator ROCKEFELLER. All right. Thank you.

Dr. CUSTER. Health insurance costs in the private sector are not currently distributed among all players. Ultimately, the costs of employment-based health insurance are borne by employees in the form of lower wages and salaries, lower levels of other benefits, and fewer jobs, and by consumers in the form of higher prices for goods and services and by taxpayers.

The distribution of these costs depend upon the size of the employment-based group, the employer's market power and labor and output markets, and the demographics of the insured work force.

Health reforms have built upon the employment-based system to more equally distribute the benefits of that system; either lower the cost faced by groups without health coverage in an effort to encourage them to purchase health benefits, or require that those groups purchase health insurance from either public or private plans. Both of these approaches redistribute the cost and the benefits of health care services.

Small employers often face higher and more variable costs of providing health insurance benefits in larger groups because of higher administrative costs and an inability to pool risks.

Small group reforms that move toward community rating and limit the risk factors that can be used to determine premiums increase the cost for procuring health insurance for groups with rel-

atively good risks, while lowering insurance costs for relatively poor risks.

In a voluntary system, some of these better risk groups may choose not to purchase health insurance. In any case, small group reforms, by themselves, may not lower the price of insurance sufficiently to encourage many of the presently uninsured to purchase health benefits.

Requiring all employers to provide health benefits to workers and dependents would decrease the number of uninsured from 36 million to 10 million.

Because many of the uninsured work for small firms, exempting employers with fewer than 25 employees would only reduce the number of uninsured to about 25 million.

This analysis assumes that there are no changes in employment as a result of an employer mandate. Clearly, if a mandate were implemented without a transition period and other elements of total compensation do not adjust, the cost of labor would increase substantially.

EBRI has simulated the effect of that and has estimated that between 200,000 and 1.2 million workers could become unemployed as a result of a mandate that employers provide health benefits. Again, these estimates assume that wages and other benefits do not change as health benefits are added.

Our simulations also found that the cost of an employer mandate will be borne primarily by small employers and their employees. We estimated that an illustrative employer mandate would increase spending by employers for health benefits by between $33 billion and $86 billion. Over 60 percent of these costs will be borne by employers with less than 25 employees.

Pay-or-play proposals limit the costs that employers would face under an employer mandate by allowing employers to pay a payroll tax rather than provide health benefits.

We simulated that between 33 and 51 percent of Americans would be enrolled in the public plan under an illustrative play-or-pay proposal if the payroll tax were set at 9 percent, and all employers who had health benefits greater than nine percent of payroll dropped their plans.

The percentage of the previously uninsured who would gain coverage through an employment-based plan ranges from 43 to 78 percent. If wages and other components of total compensation do not adjust, some unemployment would occur also in a play-or-pay plan. We estimated that between 130,000 and 965,000 jobs could be lost with a 9 percent payroll tax.

The proportion of employers who would actually drop their health benefits if a play-or-pay proposal were enacted depends upon a number of factors, but, most importantly, the characteristics of the public plan.

If the public plan were considered inferior to private plans, employers might continue to offer their private health benefits in order to gain a competitive advantage in the labor market.

In conclusion, let me say that the absence of national health care reform does not imply a static health care delivery system. Public and private purchasers are independently developing and imple-

menting cost management strategies that will potentially have profound effects on cost access and the quality of health care services.

I would be happy to answer any questions you may have. Thank you.

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

Senator ROCKEFELLER. Thank you. Dr. Shea, do you want to go next, sir?

STATEMENT OF DANIEL SHEA, M.D., PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, WASHINGTON, DC

Dr. SHEA. Thank you, Senator Rockefeller, members of the committee. I am Dr. Dan Shea, and I am President of the American Academy of Pediatrics.

I am here today representing 43,000 members who are dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. Thank you for inviting me here to address the important issue of children's access to health care.

The American Academy of Pediatrics commends the Chairman and members of this committee for their legislative efforts to bring about health care reform.

While there are a variety of proposals, we are all agreed that health care reform must be addressed. My message today is simple and direct, and there are three principles.

The first principle is that all children must be guaranteed financial access to care. The second principle is that an appropriate benefit package be spelled out and guaranteed. The needs of children must be addressed up front as Congress considers reform. Preventive care must be included and specifically defined, not left to chance in legislation, and it must be appropriately funded.

The third principle is that we must establish a single-tier system where children's benefits are uniform, whether in a public plan, or from the private sector. We cannot assume that by providing basic benefits for everyone that children will be served well.

The fact is, children are different and have unique health care needs. Currently, most proposals focus on adults and their acute care benefits while remaining vague on preventive care for children.

To ensure that the needs of children are addressed, the AAP has developed a proposal entitled, "Children First," providing for financial access for all children through age 21, and for pregnant women.

Congressman Robert Matsui, of California, turned the academy's Children First proposal into legislative action by introducing H.R. 3393, the Children and Pregnant Women Health Insurance Act.

H.R. 3393 is a play-or-pay plan which establishes health care as a right for all children through age 21 and for pregnant women. It serves as a first step toward other legislative proposals that could cover the entire population.

By building upon an employer-based system of private health insurance, it avoids the major disruption to our current system. Importantly, we expect that legislation similar to the Matsui bill will soon be introduced in the Senate.

H.R. 3393, we believe, serves as the benchmark for the AAP to evaluate all other House and Senate health care proposals as to how they address children's needs.

Unlike most proposals, this legislation spells out in detail and guarantees these child-specific benefits. It calls for a defined basic comprehensive benefit package for both public and private plans.

The benefits break out into three baskets. In the first basket are preventive care services, and these include scheduled office visits, immunizations, prenatal and newborn care, and preventive dental services.

The schedules of preventive care for children and prenatal care for pregnant women are based on the AAP and the American College of Obstetrics and Gynecology. There is no co-insurance applied for these preventive services.

In the second basket are primary major medical services that include hospital, the services of a physician, nurse midwife, nurse practitioner, and most other health professionals.

In addition, diagnostic tests, durable medical equipment, acute dental care, prescriptions, and medically necessary nutritional supplements would be covered.

The third basket includes mental illness and substance abuse treatment, speech, occupational and physical therapy, hospice, and respite care, and short-term skilled nursing facility services. Co-insurance applies to the second and third baskets.

H.R. 3393 also addressed the problems of Medicaid, establishing a one-tier system of medical care by replacing with private insurance the portion of the Medicaid program currently serving children and pregnant women, and by requiring uniform comprehensive benefits.

Additionally, H.R. 3393 does address cost containment. It achieves savings through the promotion of preventive care, cost sharing, and care coordination of medically complex children.

The legislation establishes a resource-based relative value scale for pediatric and obstetric services, but it is important to understand that children are not a significant factor in the increasing health budget.

In fact, persons under 19 are nearly 30 percent of our population and consume 10 percent of our health care expenditures.

Let me conclude by saying that the search for consensus on health care reform is now under way. The academy strongly believes that such consensus can, and must begin with the health care of our children and pregnant women, as outlined in H.R. 3393. It spells out in detail and guarantees these health benefits that children require.

The American Academy of Pediatrics urges prompt congressional action to ensure that children will have access to health care that they have a right to. We look forward to working with the Congress in considering this issue. Thank you.

Senator ROCKEFELLER. Thank you, Dr. Shea.

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

Senator ROCKEFELLER. Dr. Griner.

STATEMENT OF PAUL F. GRINER, M.D., PRESIDENT-ELECT, AMERICAN COLLEGE OF PHYSICIANS, ROCHESTER, NY

Dr. GRINER. Thank you. The American College of Physicians is pleased to have this opportunity to present our recommendations on comprehensive health care reform.

With more than 76,000 members practicing internal medicine, the college is the Nation's largest medical specialty society. I am Dr. Paul Griner, president-elect of the college.

And, Senator Rockefeller, I would like to begin my remarks with a reply to a basic question that you and others raised this morning, and that is, how one controls health care costs.

Our proposal addresses cost containment through a combination of control of supply and reduction in demand.

A combination of market forces including more organized and integrated delivery systems and thoughtful, regional regulation based on need would constrain the supply of facilities, technology, and manpower.

And reduction in demand would occur through administrative, benefits, and tort reforms, more explicit criteria of good medical practice and improved patient participation decision-making.

In brief, we feel that cost control measures must be married to global budgeting and rate setting to avoid the problem of business as usual with less money.

We are committed to the principle that universal access to care can be achieved only through reform in the organization and financing of health care.

And our position will outline a national policy to achieve that reform through four central elements: assuring access to care; assuring high quality and comprehensive health care; controlling costs; and promoting innovation and excellence.

We propose a universal insurance system with two streams of financing: one private, and one public. Everyone would have health care insurance; covered benefits would be the same for all.

We envision an integrated system in which employers and government would sponsor and support a range of insurance plans which, in turn, would offer alternative practice arrangements from traditional fee-for-service to a variety of organized delivery systems.

Patients and providers would not perceive any distinction between employer-sponsored and publicly-sponsored plans because there would be no difference, except for the source of financing.

Our plan is designed to encourage employers to provide insurance by taking steps to help insure that coverage is more affordable and premiums more predictable.

We propose phasing out employer responsibility for retirees and providing coverage for all patients who face catastrophic medical costs through the public, as opposed to the private system.

The goal is to establish healthy competition between the public and the private side to avoid conditions where employers opt to pay because of high premium costs rather than to play.

Our support for an insurance-based system is grounded in our belief that it will foster a wide range of practice arrangements of benefit to patients and providers. We also believe in decentralized administration under national criteria.

But substantial insurance reform is needed. Legislation such as that sponsored by Senator Bentsen and others contain many of the reforms that we support, such as elimination of exclusions for preexisting conditions, adjusted community rating, and guaranteed insurance. But we feel these requirements must be in the context of comprehensive reform.

Without cost containment strategies, new requirements for the insurance industry might simply increase costs for the majority of small employers and their employees.

Benefits reform is needed. The ACP proposes a benefits determination process that is patient-specific and medically-oriented. We object to predetermined basic benefit packages that are designed to limit rise without adequate attention to the needs of patients.

Benefits determination should be structured to address whether a service is effective, valued by society, appropriate for a particular class of patients or clinical circumstances, and, finally, appropriate for the specific patient.

We propose substantial reforms for liability determination, as well as strengthened efforts by the professions and licensed authorities to monitor physicians and correct problems. And, for the sake of time, Senator, I will defer further remarks on malpractice reform.

Cost control mechanisms are essential, as I indicated before. We propose a national health care budget that sets limits on total spending and drives a series of measures to address price, supply, and demand for services.

The budget would be set at the national level, taking into account variables such as the changing health needs of the population, new technology, and general inflation.

A national commission, in consultation with State authorities, would develop a budget for each State based on its population and disease burden. Operating within State budgets, the States may choose to establish or recognize regional authorities that would further oversee health care spending within the State.

States would be required to establish mechanisms for the publicly and privately sponsored insurance plans to negotiate with physicians, hospitals, and other providers.

In order to control costs, we believe that there needs to be some regulatory overlay to complement market competition. The incentives of the current system must be changed to correct the maldistribution of health resources that include manpower, technology, and facilities.

We must change our thinking about regulation from the micro-level of the individual physician/patient encounter to the macro-level that deals with supply or inputs to the system.

So, we propose that States and communities, under Federal guidelines, establish targets for the supply of health resources—such as physicians, hospital beds, and major technologies—and introduce controls to help avoid excesses of these resources.

We are fully committed to reform of the health care system. We will be developing further refinements to our position over the summer and hope that our comments today are useful to the committee as it moves forward on this shared goal. Thank you.

Senator ROCKEFELLER. Thank you, Dr. Griner.

[The prepared statement of Dr. Griner appears in the appendix.]
Senator ROCKEFELLER. John Motley.

STATEMENT OF JOHN MOTLEY, VICE PRESIDENT FOR FEDERAL GOVERNMENTAL RELATIONS, NATIONAL FEDERATION OF INDEPENDENT BUSINESSES, WASHINGTON, DC

Mr. MOTLEY. Thank you, Mr. Chairman. On behalf of NFIB and its more than 550,000 members across the United States, I want to thank you for the opportunity to appear here today to discuss one of the proposals before the committee, which is more commonly called play-or-pay.

I would also like to submit, along with my testimony, two papers which were done by the NFIB Foundation, one entitled, "It is Cheaper to Pay Than to Play," and the second one is, "Taxes Based on the Inability to Pay; Another Effect of Play-or-Pay."

Senator ROCKEFELLER. They will be included.

[The prepared statement of Mr. Motley appears in the appendix.]
[The papers appear in the appendix.]

Mr. MOTLEY. Thank you, Mr. Chairman. I will not repeat what we have said in a number of testimonies before this committee before. Let me simply state that the cost and availability of health insurance remains the number one problem facing small business in America today.

In March of this year, along with VISA, NFIB released its most recent "Problems and Priorities" study. The cost of health insurance was number one, but now it has twice the importance of the number two problem being faced by small business, which is the impact of Federal taxation.

Ninety-four percent of NFIB members polled in the last several years oppose a play-or-pay solution to the health care crisis. That is 10 percent more than oppose a national health insurance proposal. I believe that they oppose this proposal for five reasons.

Number one, small business owners believe that the provision of health insurance is a fringe benefit, it is not an automatic component of wages or compensation.

If it is to become an automatic component, then I believe that that type of cost and responsibility should be shared by society as a whole, and not by the employer community of the United States.

Number two, Mr. Chairman, the current proposals are funded by, at least in most cases, open-ended payroll taxes. That is on top of the current Social Security payroll tax, on top of unemployment compensation, and most employers would also consider worker's compensation to be a payroll tax. This is a significant addition to payroll and to the cost of creating jobs in this economy.

Number three, we believe a payroll tax is regressive; that it impacts lower wage earners more than others, and struggling businesses more than others. Firms that do not provide health insurance in this country today have three times the number of lower wage earners than firms that do.

According to NFIB's health surveys, those firms, where the owner takes over $70,000 a year out of the business, over 90 percent of them provide health insurance to their employees. Only one-third of those that take $20,000 out of their businesses provide health insurance.

Fourth, we believe that the proposals before the committee impose a relatively expensive Federal standard plan which is beyond the means of many small employers, particularly those who are not doing well enough to afford it.

And, last, Mr. Chairman, but most importantly, we believe that it destroys jobs and puts many small businesses in America at risk.

Whether you force a small business to purchase a health insurance policy or to pay an excise tax, the effect is the same: it increases the payroll cost for that business.

There are only three possible responses. One, is to raise prices. Most small business in our economy are highly competitive, but they are competing with Sears, Wal-Mart, and other stores who have a lot more market presence than they do.

The second choice is to absorb costs, and when 40 percent of the small business community in this country make less than $30,000 a year, there simply is not that much elasticity to absorb costs.

Third, is to reduce payroll. I believe—NFIB believes—that the response will be arithmetic in that area. Let me just take an example. If I am a small employer and I have 10 employees all roughly making $10,000 a year—the figure is just picked for ease of computation—and we added a $3,000 health insurance policy on top of that, it is $30,000 more a year in payroll costs.

Now, let us say I do absorb $10,000 of that. My only other choice is to let go two employees to pick up the $20,000 to cover the other eight that I still employ.

And we at NFIB believe that that will be a very typical response by many small business owners. And that is why many of the studies that have been released in the last 6 to 9 months indicate that there will be job destruction. You just heard the witness down at the end of the table testify on the results of EBRI studies.

The COMSAT Research released a study saying that it would be 9.1 million jobs at risk in the country; and the Joint Economic Committee puts the figure at 712,000 jobs.

To us, destroyed jobs and the higher cost of providing new jobs equals more people on public assistance and more people eligible for the public side of the health insurance program.

In conclusion, Mr. Chairman, for these reasons, and for many more which we have enumerated in this testimony and others before this committee, we remain very strongly opposed to the play-or-pay or mandated concepts being put forward. We continue to support the Chairman's bill, S. 1872, as a reasonable and doable first step, one that will provide some relief to the small business community. I will try to answer any questions that you might have. Thank you.

Senator ROCKEFELLER. Thank you, Mr. Motley. Mr. Sheils.

STATEMENT OF JOHN SHEILS, VICE PRESIDENT, LEWIN-ICF, FAIRFAX, VA

Mr. SHEILS. Thank you. I was asked to discuss our estimates of the reduction in national health spending under the cost containment provisions of the Health America Act. These cost containment provisions are among the bill's most important features.

Between 1980 and 1990, health spending as a percentage of Gross National Product increased from 9.1 percent in 1980 to 12.3

percent in 1990. Yet, despite this massive infusion of national wealth into our health care sector, the number of uninsured persons in this country increased by 10 million persons during that same period. The relationship between cost and access is a simple one.

As health care costs rise, fewer and fewer employers and families can afford insurance. Effective cost containment will be necessary just to maintain even the current level of insurance coverage, let alone its importance in expanding coverage.

The Health America Act includes several significant cost containment initiatives designed to reduce unnecessary health spending. It also establishes a Federal health expenditures board charged with setting national health spending targets and negotiating provider reimbursement levels that are consistent with these spending targets.

In prior testimony, we estimated that the savings in national health spending under these cost containment provisions would be about $83 billion in the first 5 years of the program.

However, these savings would be partly offset by an increase in utilization by previously uninsured persons so that the net savings under the bill at that time would have been $46 billion.

Since that time, the Senate Committee on Labor and Health has amended Health America to greatly enhance the effectiveness of the health expenditures board.

These amendments give the board the authority to unilaterally impose provider reimbursement levels which are consistent with national health spending targets. We estimate that this enhanced authority will increase the net savings under the Health America Act to as much as $215 billion over the first 5 years of the program.

The long-term stability of Health America hinges on effective cost containment. Clearly, it is essential to stabilizing Federal costs under the program, but it is also vital to maintaining private insurance as an attractive alternative to covering workers under the public program under the pay-or-play program.

In fact, effective cost containment will be vital in maintaining the stability of any health care financing system, including the one we now have.

Now, Mr. Chairman, I was also asked to discuss the potential for lost employment under the Health America Act, and I would like to take a minute to summarize what we have learned.

As you know, under the Health America Act, employers will have the option of providing insurance or covering workers under a public plan by paying a payroll tax currently contemplated to be about 8 percent of payroll.

Most economists agree that any loss of employment under the plan will be concentrated primarily among minimum wage workers. Since most employers of low-wage workers are likely to choose to pay the tax rather than provide insurance, Health America represents an increase in compensation costs for minimum wage workers of about 35 cents per hour. That is 8 percent of $4.25 an hour, the minimum wage.

The question is, how will this increase in the effect of minimum wage affect employment? There is a remarkable degree of consen-

sus among economists that the loss of employment due to increases in the minimum wage has historically been small.

Most of the employment loss has been concentrated among young teens, many of whom will be exempt from the coverage requirement. Although some reductions in employment are expected among young adults, increases in the minimum wage have historically had little measurable impact on adult employment.

Based upon a review of the literature on the minimum wage, we estimate a loss of employment under the Health America Act of between 23,000 and 63,000 jobs.

This estimate is consistent with independent job loss estimates for employer-based insurance expansions developed by Dr. Kenneth Thorpe, Dr. Karen Davis, and the Congressional Budget Office.

This concludes my prepared remarks. I apologize if the testimony was a little eclectic.

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

Senator ROCKEFELLER. No. Thank you all very much. What I would like to do is just ask one question of each of you, and I will start with you, Dr. Shea, then work to Dr. Griner, Mr. Motley, Mr. Sheils, and then Dr. Custer, if I could go in that order.

Some would make the case that our health care system has gone crazy. Bernie Tresnowski used the phrase "melt-down," that the possibility of a melt-down is genuine. I happen to believe that. Most people think that the cost of health care will be between $1.5 trillion, $1.8 trillion, maybe $2 trillion in 7.5 years.

So, the cost of doing nothing is something that interests me. When Lloyd Bentsen talks about doing health insurance reform, he always couches that as being the first step. Therefore, at no point do I, or any other student of this, look upon that as sort of what we do to get health care under control. It would be a first step. Would it be an acceptable first step, that is a question that has not yet been decided.

But my question of all of you, starting with you, Dr. Shea, is what is the cost of doing what we are doing right now, which is debating this issue at length, in effect doing nothing about it?

Dr. SHEA. The cost of not doing prenatal care presently, we factored, with Lewin-ICF, is $1.8 billion per year. The cost of not doing anything with regard to immunizations is in a 10–14 fold cost to pay later for not immunizing.

The global cost of not doing anything, I am unprepared to tell you. But I can tell you that in the corner of the world that we work in, doing nothing is a disservice to children and pregnant women, is a cost to the United States dollar-wise and in tragedy, and I think it is intolerable.

I am not going to use the term "melt-down." We have too good a system in place. It needs help, it needs reworking, but we have too good a system to describe it as about to melt down.

Senator ROCKEFELLER. Dr. Griner.

Dr. GRINER. Senator, the costs are enormous in a number of areas. One, obviously, in the area of unmet health needs, the principal concern. Dr. Shea just reflected on that.

I would focus particularly on unaddressed health care needs in inner cities and rural areas beyond the generic issue of the total number of uninsured.

We also have a major cost in terms of the unraveling of the infrastructure of primary care and internal medicine throughout the country as a result of enormous problems with dissatisfaction, hassle, and all of the administrative concerns that have been described before.

And, finally, the concerns that are quite legitimate of industry and business in losing their ability to compete effectively, both internally and throughout the world.

Senator ROCKEFELLER. Mr. Motley.

Mr. MOTLEY. I think that the first word that would come to my mind is fear, fear by small business owners that they are not going to be able to continue to provide health insurance for their employees, their employees' families, themselves and their families. You will see frantic efforts to try to control those costs and everything failing over the years; and then eventually reaching the only possible decision for some of them. That is, calling everybody together, say they are going to give them a couple of thousand dollars more a year in salary, but they are on their own in terms of purchasing health insurance. You will see fear that they are going to expose themselves and their employees to situations that they cannot control and will not be able to get help for in the future. I believe we have provided the committee with witnesses of that type in the past. But that was only one isolated instance. I hear that story a dozen times a week from NFIB members across the country.

Senator ROCKEFELLER. So, that is if we do not take the situation and do something with it, these are the fears that your people would express?

Mr. MOTLEY. Absolutely. It is fear that they are just going to have to eventually have all of their employees fend for themselves. And they do not want to do that, Mr. Chairman. Two-thirds of our members provide health insurance.

Of the one-third who do not, two-thirds would like to provide health insurance. So, most of the employers, roughly 90 percent in this country, at least by our polling, would like to be able to provide that as a fringe benefit.

Senator ROCKEFELLER. Thank you, Mr. Motley. Mr. Sheils.

Mr. SHEILS. Senator, Ouver Reinhart has an assignment he gives in one of his classes. He gives his students projected rates of growth in GNP and health care costs and he asks them to calculate how long it will be before health care consumes 100 percent of Gross National Product. And I do not know what the answer is, 30 or 40 years.

But the point is, that is ridiculous. Health care costs will never consume 100 percent of GNP. Health care costs will level off eventually. This cost growth curve will bend back on itself. The question is, how will it bend back on itself?

Will it bend back in such a way that the only people who have access to health care are higher income persons? Will health care evolve into a luxury good? Or will it bend back on itself in such a way that everyone has access to health care, that access is preserved and expanded?

Public policy intervention is required to help us shape the outcome, to help us decide which of those outcomes we will see in this country.

Senator ROCKEFELLER. Thank you, Mr. Sheils. Dr. Custer.

Dr. CUSTER. Thank you. The problem with health care now is that the benefits and costs are not distributed equally. As health care costs continue to rise, those distributions are becoming more unequal and will continue to become more unequal.

What is happening now and has been happening for the last decade is the health care services market has been changing rapidly, both the way it is being financed and the way it is being delivered.

And the leaders of that movement are the large employers who have the wherewithal to expand the administrative funds to try to manage their costs.

What I see in the absence of any government changes is that those employers, those systems that can exert some market power, that can make changes, will see changes, but that those smaller employers and those individuals who are now outside the system, that segment will grow.

Senator ROCKEFELLER. Thank you, Dr. Custer. I have a variety of questions, but let me go, now, to John Breaux, if you have some.

Senator BREAUX. Thank you, Mr. Chairman. And thank the panel for being with us and your presentations. I had asked, Mr. Motley, Mr. Magowan, representing the larger businesses, whether they felt that there was an obligation on the part of employers to provide health insurance to their employees, and I would ask you the same question.

Mr. MOTLEY. Let me answer. We asked that question in the surveying that we do, and most of our members believe that it is not an obligation of employers to provide health insurance.

They believe that individuals have obligations in those areas themselves. I would qualify that by saying that most of them would very much like to be able to provide help in that area.

Senator BREAUX. I was interested in some of Mr. Sheils' comments about what happens if we had the play-or-pay type of plan, what does an employer do with regard to the extra cost. And you basically say you are going to cut wages, or you are going to increase prices. And I think Mr. Motley was referring to that for small business, an obvious problem that they are not going to compete. It is going to be an inordinate burden on small business, as compared to larger businesses.

Do any of your studies indicate anything that you would like to add to that? I mean, I get the impression from Mr. Motley that small businesses just cannot afford to do either and still stay competitive.

Mr. SHEILS. Senator, I think that the expectation is that, over time, most of this will come out of individuals' wages; that over time the employers will probably slow the growth in wages relative to what they would have been in the absence of this so that they can meet their costs, so that they can stay within the constraints of their market.

Senator BREAUX. But many of these would already be at minimum wage, though, would they not?

Mr. SHEILS. That is right. And it is when you get to the minimum wage workers that you really do have to concern yourself with the potential for loss of employment. It is there that the em-

ployer is prohibited by law from lowering the wage level so they can recover the cost of providing the insurance.

However, it is widely believed that many employers will be able to pass much of this on in the form of higher prices. Minimum wage workers tend to be concentrated in certain industries, in certain sectors of the economy.

I will give you an example. You have got two fast-food establishments across the street from each other. One can hardly offer insurance, because that means they have got to raise prices and they will lose market advantage.

But if both fast-food establishments have to do the same thing, if they both have to pay this tax or provide insurance, then the price of a hamburger in both establishments goes up by a dime or a nickel apiece.

And it is believed that, to a large degree, that this added cost in that environment could be passed on to the consumer in the form of higher prices. And, in fact, economists will offer that as one of the explanations for why the loss of jobs under increases in the minimum wage has not been larger.

Economists have always been surprised at how small the job loss was, and this is one of the explanations that they have offered to explain why the job loss was, in fact, as small as it was under minimum wage increases.

Senator BREAUX. Mr. Motley, what about that argument? As I understand it, the consumer, according to this, is ultimately going to pay for it.

And if we are basically affecting people in the same segment and everybody raises their prices, they are still competitive because they all had to do the same thing in response to the extra cost.

Mr. MOTLEY. I think you will find many small businesses simply are not in a position to react like that.

I think what we have to remember is that in the lower end of our economy, which is extremely dynamic, we have many, many firms coming into existence every year and many firms going out of existence for a number of reasons, and they are subject to the economic cycle.

Firms in New England today are still in very, very difficult straits, and firms in other parts of the country are doing quite well.

Where I see this having the greatest impact is among new and struggling firms; those firms which are really just holding on for one reason or another, and because you are setting this in just like Social Security taxes.

Whether they make money or not, they are going to have to pay it. And when you get down to that minimum wage employee, there is no more room to go.

I see it having a tremendous effect just in the area probably where you do not want it to have an impact, and that is in the lower wage earners and the smaller firms on Main Street who simply cannot make it in the economy.

Senator BREAUX. Maybe just one more question. If the only thing the bill did was to require all employers to require health insurance, we obviously then are looking at increased costs.

But there is a second part of it, as Mr. Sheils points out, and that is the cost containment portion of the legislation. And he

points out that while increases in costs are likely, he said increases in costs are likely to be more than offset by the savings that result from the program of cost containment proposed under the bill.

So, I guess what you are suggesting is that it is a two-prong approach. You are going to have increased costs, but they are going to be offset because you are going to have cost containment, which we do not have now.

Mr. MOTLEY. Are those costs not going to be offset for those people who now have insurance and who are finding it difficult to provide it? It does not seem to me that you are going to offset the costs for people who do not provide insurance where you have a whole new cost of business coming in. That is a cost which will never be recouped through the cost containment measures that are there.

It is an annual outlay. You are now saying whether it be $1,000 or $3,000, or it be 12 percent of payroll, or 7 percent of payroll, you are going to provide that every year, Mr. Employer.

And all the cost containment is going to do, frankly, is hold it to 7 of the 12 percent and make sure that it does not get up to 15 and 20, which will be a disaster.

Senator BREAUX. Any thoughts on that, Mr. Sheils?

Mr. SHEILS. Yes. We do a lot of work with State commissions who are appointed to address these issues at a State level. There is a lot of work going on out there, and these commissions often include a cross-section of business and provider groups.

Small business is almost always represented on these commissions, and in talking to the small business representatives, their greatest fear appears to be the concern that, while it might be a 7 or 8 percent payroll tax right now, what is it going to be down the road?

How high is it going to be down the road if you do not control costs? And their concerns are well-founded. In the absence of effective cost containment programs with real teeth in them, their concerns are absolutely justified.

The tax rate, the cost of insurance is going to go up at the same rate. The health care system is viewed by many employers as a sinking ship. And they are very unhappy with the thought of being mandated to climb aboard until we plug the leaks.

Mr. MOTLEY. I would agree very much with what was just said. I do think there is one significant difference, though. Those people who now provide health insurance are extremely fearful that if they are required to provide a significant level without heavy cost containment and controls that are in there, that they are going to be placed in a lose-lose situation.

Senator BREAUX. Yes. Well, I do not think anyone is arguing or advocating that we do the requirement without cost containment. I mean, I have not signed onto the bill, but I would never want to do it unless we had some cost containment provisions.

Just to say everybody has got to provide health insurance without addressing the cost is just half of the pie, and it is not nearly enough. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you. Senator Riegle.

Senator RIEGLE. Thank you, Chairman Rockefeller. Mr. Sheils, the company you represent has done these independent estimates of the cost-saving, cost containment part of the bill that Senators

Mitchell, Rockefeller, Kennedy and I have put together. And your number, as a 5-year saving, is about $80 billion. Am I correct in that? In terms of what is in our basic bill. I want to go to what has come out of the Labor Committee estimate.

Mr. SHEILS. Oh. All right. The savings provision should generate about $80 billion. That is right.

Senator RIEGLE. Now, the cost controls that have been included which are tougher—and I support tougher cost controls—that are in the bill that has just been reported out of the Labor Committee, I understand that your estimates are that the 5-year saving there is $260 billion. Is that right?

Mr. SHEILS. $260 billion savings. I encourage people to offset the increase in utilization for previously uninsured persons. Once you take that into account, you get a $215 billion net savings under the program. That is the bottom line.

Senator RIEGLE. Well, I think that is positive and encouraging, and it sort of comes off where we are now. I mean, the whole approach of going in the direction of improvements in our present system, substantial improvements, that can start to bridge some of the gaps, I think is the route to go.

There are some who say, do little or nothing, just a little tinkering around the edges. I do not think that is a viable response, given the way the problem is growing. And there are some who want to go to the full Canadian-style plan, or the single-payer plan, and so forth.

And I have not been able to convince myself that that is what we ought to do. I like the in between type; I do not like the title that it carries. But it does have to have the strong cost controls.

Now, let me just review for a minute. Every business organization that has come in to see me, from large to small, the biggest companies in America, General Motors, Ford, Chrysler, and others in my State, and a lot of other large outfits, but my smaller companies as well, and very small ones, including the summary of the Chamber of Commerce position, the NFIB position, am I right, Mr. Motley, in thinking and believing that in terms of the list of issues that are of greatest concern to your members that the cost of health care is number one on the list right now?

Mr. MOTLEY. Yes, it is, Senator.

Senator RIEGLE. It is number one. I am finding that with every other business organization, no matter how large or small. So, the fact that smaller businesses are saying that is absolutely consistent with what bigger businesses are saying.

Of course, bigger businesses oftentimes tend to be locked into labor contracts where they have got even more expensive plans, and they are in international competition in many cases, and they feel they are really getting killed. They come in with their own perspective and their own sense of urgency.

But I am convinced from what I see that if we do not move quickly with some major avenue of reform, that business throughout the country is going to be damaged further. I think it has been damaged already.

Most business people that I talk to want to maintain health coverage if they possibly can. I just talked to a small business operator in Northern Michigan who finally got squeezed so much that he

had to discontinue the health care coverage for his workers, and even for himself, even though he is the person that, in effect, has to keep the business going.

And he talks about it with such pain and frustration because it is the last place he wants to get to, but he has been squeezed into that corner because the costs have just gotten to the point where they just are not manageable.

So, I would hope that we would not get imprisoned in set positions that do not let us work to some common position that may not be everything that everybody wants.

It might not be, for example, Mr. Motley, that we can have something that is going to be precisely what you want, any more than it is precisely what I want or somebody else wants.

Let me tell you what I think we can get if we are willing to move and get to sort of a balance point. I think we can get serious cost controls that will really make a difference for business in this country. I think that is achievable. I mean, if we set that as a goal and we go for that goal together. There are a lot of elements in that; I will not get into them.

I think we have got to have the broadening of coverage as well. We start out by bringing in expectant mothers and children up to the age of 19.

You were probably in the room when I held up that article about this little six-year-old in Michigan who has a working mother and has no health insurance. It is just inexcusable. I do not know whether you have children; I certainly do. Our kids have to be covered. America's kids have to be covered under some kind of an insurance plan. It is just absolutely essential. We should not go another day without it.

And the fact that we cover the children of the Members of Congress, the President, and the Vice President, and so forth, and I think probably all of you enjoy insurance coverage that covers your families, the Nation that we can sort of be a bifurcated society and just sort of forget about everybody else who is not in that situation, no other modern country is doing that. They are all finding a way to get the job done in terms of getting the coverage, and we have got to have it, too.

So, I guess what I would ask you to do at this point, I have said many times and I will repeat here now—I think Senator Rockefeller has expressed this view and I know Senator Mitchell has—we are not locked in stone on our plan.

We are prepared to change elements of the plan. There are parts that I think ought to be a lot tougher in the cost control area. In fact, I think maybe we even ought to go beyond some of the things that are in the bill reported out of the Labor Committee.

But if we stay sort of locked in positions where we make it appear that there is no way to overcome the differences and get to a common point, we are going to be back here next year and the year after.

Maybe not if Perot gets elected President, because he says he is going to solve that problem and he may just do it. So, I do not say that tongue-in-cheek. But I do not think that helps anybody.

I think anybody who wants to be a purist on this issue now really ought to get out of the debate, because I think it is holding back

reforms that could be had that would be good for everybody; small business, medium-sized business, large business, and people in the country that need health insurance.

So, my appeal to you is that we all work now to try to find that middle ground that can sort of break this polarized debate and discussion. And I am prepared to go there with you.

We started out that way when we drafted our bill, with a bipartisan group of 15 Senators, essentially evenly divided between the two parties, and the principals in our bill came out of that bipartisan working group.

But my hope would be that you would work with us now to try to take and formulate a package that may not be precisely to your liking, but one that would be better than what we have now. And that is really your choice.

The choice now is more of the same: the increasing weight of a system that is breaking down, or intelligent reform and change. Those are the choices. And if we do not come together on intelligent reform and change, we are going to get more of what we have got now. So, that is my appeal to you. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Riegle. That is a Senator Riegle classic. [Laughter.]

Dr. Griner and Dr. Shea, I do not mean to be ignoring you two folks. I do not want you to feel that you are unloved or unwelcome here. Both of you have made very significant contributions.

Dr. Griner, I have got to say that you deal with cost containment more effectively than Dr. Shea does. And Dr. Shea appears to me to be saying, kids are too important, and they are not that big a part of the equation. Therefore, cost containment may have to apply elsewhere.

I want, Dr. Griner and Dr. Shea, each of you to explain to me why you came to your views on cost containment. And, Dr. Shea, in your case particularly in that cost containment seems to be missing more in your proposal, although the pediatricians' proposal is a superb one.

Once you establish an architecture for pregnant women and children and you do not establish that architecture minus ingredients like cost containment, I mean, you cannot say no for children and yes for others, in my judgment. If you could both comment on that, I would appreciate it.

Dr. GRINER. Who would you like to go first, Senator?

Senator ROCKEFELLER. I am neutral.

Dr. GRINER. Let me, if you will, respond to the question of the college's position on cost containment. As you would infer from my statement, there are many provisions of our proposal that are either similar to or virtually identical to the Health America Act.

I would say that the one area that the college is taking a very strong supporting position on containing capacity that goes further than HealthAmerica. That is to say, manpower, both the number and mix of providers, and capital, facilities, and technology.

We do not feel that market forces alone, managed care alone, or managed competition alone will be sufficient to gain control over costs without the overlay of thoughtful regulation of supply.

I come from a city, Rochester, NY, where we have the lowest per capita costs in the country, with almost universal access to services

that are of high quality. We have achieved that over a 40-year period largely through containing capacity. And most of the people in the system in Rochester, whether providers, patients, or payers, are quite happy with the system.

I am speaking, now, as a representative of a community that has been able to achieve this rather than my role at the American College of Physicians. But the two hats that I wear are quite complementary on the capacity control side.

So, at would be our major point, and it supports, also, the position of the National Leadership Coalition on the need to control capital.

Senator ROCKEFELLER. Dr. Shea.

Dr. SHEA. Senator, I am glad to have this opportunity to respond. kept my comments under 5 minutes, so I was not able to there. But let me remind you that in my formal comments, I talked about preventive care and I illustrated two facets of preventive care that would return to the health budget one-half of what the Federal expense would be with our proposal. So, do not down-grade preventive care as a cost-saving.

The next would be the cost-sharing that we would expect from employers, employees, and from the public sector patients who can afford it. The next would be the care coordination for medically complex children, because they take a great deal of our health budget, even though our health budget is minuscule compared with the general health budget.

But let me take this a step further. The Matsui proposal calls for a national advisory committee that would be appointed by the Secretary of HHS. This committee would be comprised of health experts from various disciplines: pediatrics, obstetrics/gynecology, general medicine.

Senator ROCKEFELLER. To do what?

Dr. SHEA. I will finish. This national advisory committee, using PPRC and PROPAC input with regard to relative values for physician services and hospital services then would determine reimbursement and the conversion factor that would play into it that would assure first-quality, and, secondly, accessibility of services.

And that recommendation would be made to the Secretary of HHS, and the Secretary, then, could determine the reimbursement factors that would pertain. The important thing to remember here is that we have searched for that magic number that children and pregnant women would require next year, the year after, and the year after, and it is an unknowable number to us. And this is why we did not elect to go with a national cap or an expenditure target, because we have had 25 years of children being short-changed under Medicaid in the name of cost containment. We do not want costs contained to their detriment.

Senator ROCKEFELLER. No. I understand that entirely, Doctor. I understand the sentiment, I understand the Medicaid history. We, of course, get rid of Medicaid, because we have the same view that is a lousy program that you have.

But to say that because the 25 past years have been confusing and the future is potentially inept, to say that, therefore, we cannot get into real cost containment which has to include expenditure targets, expenditure caps, or whatever, negotiated rates. Based

upon all of that, is to separate yourself from the cost containment movement in the interests of the care of kids.

Dr. SHEA. But we have a history for it. Children have been the least well-served population in the United States over the past two decades.

Senator ROCKEFELLER. I understand that. But you understand if the first thing we are to do in the Congress—and I think it is the most likely first thing we are going to do—is pregnant women and children, which is right down your alley. If we come out of that without some sort of a Federal health expenditure board or some other type of rigid cost containment, that sets the pattern for the future.

You do not want kids to be the cause of destroying the possibility of maintaining the kind of health care system, at least in some measure, that we have. My question was not very articulate. Actually, I do not need you to answer.

I just want to say to you, you cannot exempt yourself, in my judgment. And you know how strongly I feel about kids. I spent all day in Pittsburgh with the National Commission on Children yesterday looking at kids at all different levels of poverty, and the horrific problems they are having getting medical care, including a lot of 15-year-old mothers who either did not want to be mothers, did not know how to be mothers, did not know anything about prenatal care and had low birth weight babies.

I mean, I am right down that track, too. But cost containment cannot be exempt for anybody. We are talking theology here. Cost containment is a sacred matter. It cannot be put aside for anybody, and the health care system is not going to work for kids unless the health care system is controlled for all, in any event, in my judgment.

Dr. SHEA. I will not refute what you are saying, and I do not want to be argumentative. The only thing I would like to say is that the budget for children and pregnant women that would assure quality and accessibility of services—which I believe is what you want—is an unknowable number.

Senator ROCKEFELLER. I am just suggesting to you that you may be, by not dealing with cost containment in a really rigorous manner, delaying the day that we get to the coverage of pregnant women and children, which I feel may be the first thing that comes out of the Congress. And I say that with great sincerity.

In other words, you may be the very first one to benefit from this glorious day that Congress finally does something. And, therefore, cost containment is going to have to be in that mix. I just suggest that to you for thought.

Dr. SHEA. We hope the children will benefit.

Senator ROCKEFELLER. Well, I want the children to benefit, too. I also want the system within which they are going to benefit to be one which can last. And I guess that is my point.

Mr. Sheils and Dr. Custer, you gentlemen have a very basic disagreement, and I want it to be on the record here. My understanding, Dr. Custer and Mr. Sheils, is that when EBRI did this analysis, the assumptions were based only on cost, but that the effective cost containment and that the elimination—which can net $215 billion—and the elimination of cost-shifting were not considered. And,

therefore, you two gentlemen come to extremely different conclusions.

And who is right and who is wrong, or who is closer, is very important, for example, to John Motley. Because if you are talking from 25 to 63 as opposed to 600,000 to 900,000 jobs lost, that is an enormous difference. And I would like you two gentlemen to have a civil discourse on your approach for a few moments, if you will be willing to do so.

Dr. CUSTER. Sure. First, we made an assumption that I do not think is tenable that wages and other benefits would not adjust. We wanted to illustrate who would bear the costs and that it would be the employees, or the final beneficiaries of the benefits. So, we made that assumption knowing that, in fact, it would very much overstate the number of jobs that would be lost.

Second, what we did and what is hard to know is exactly how effective cost containment would be in terms of determining the per capita cost of a plan, so we used a range from $900 for an individual up to $2,000.

And that is why we get this million job range in looking at straight employment because, frankly, some of these things are just not knowable, and some of these estimates are totally dependent upon the assumptions you wish to make on how people are going to behave and what the final costs are going to be.

Senator ROCKEFELLER. Well, all right. Mr. Sheils. That is not the answer I wanted. In a sense, I wanted you to contest what Mr. Sheils is analyzing, and I want Mr. Sheils to contest what you are analyzing so that I, in my infinite wisdom, can judge.

Dr. CUSTER. There is one more point that is important in terms of determining the number of people who may lose their jobs, and that is, it is not a minimum wage effect. Eleven million of the uninsured are below the poverty; at least 24 million who are above there who are in families where the head of the household is going to earn more than the minimum wage. So, it is not appealing to the minimum wage literature, I think, and understates the potential impact.

Senator ROCKEFELLER. Mr. Sheils. You two gentlemen just sort of have at it.

Mr. SHEILS. I suppose it is no accident that we are sitting so far apart, Senator. I have been working very hard to develop a system for estimating the costs of the health reform proposals since 1983.

We did not embark on that course, excepting the notion that a lot of these things are unknowable. Indeed, there is a basis for developing these estimates.

I have been doing this kind of estimation in tax policy, public policy for many, many years, and this is the difficult thing we have ever tried to tackle. But we very much feel that there is a basis for looking at this.

For example, the workers who do not have insurance today, if you were to take them as one population, an actuary, look at them as one population, you would pronounce them an excellent risk. You would do so because they include a disproportionate share of very young workers.

In percentage terms, the highest concentration of uninsured workers is in the young adult group, the young immortals, the peo-

ple who—well, I remember my utilization of health care back then and it was really quite minimal. But that is where we find that the costs associated with insuring this group is relatively low.

We have estimated, for example, that the employer's cost of complying with the Health America Act would, on average, be about $115 per month.

That would be the cost when you include the dependents, the mix of dependents, and so on. We think it would be about $115 a month under this benefits package. Would it be exactly $115? Clearly, no. But we do not think that the range is as wide as $900 to $2,000.

As for the loss of employment, the economists are routinely surprised—I mentioned this earlier—about how small the loss of employment has been when you increase the minimum wage. It just does not work with the theory. The theory falls apart.

When you look at the results, it is very surprising. And, in fact, there appears to be some evidence that employers are able to pass on some substantial portion of the costs in the form of increased prices.

There is an old joke. If you give three economists the same data base, you will get three essentially different results. That did not happen with the minimum wage literature. You came up with some differences, of course, but basically the central thrust of the conclusions is pretty much the same. We have developed our estimates, we used——

Senator ROCKEFELLER. Well, can I ask Dr. Custer to respond to that?

Dr. CUSTER. Well, again, I have to agree. I do not think the minimum wage literature is the literature you want to appeal to, number one.

Again, I want to also say that the job loss estimates we look at, we produced, were an attempt to be illustrative to demonstrate the notion that costs are reallocated under all health care reform plans.

And this one, in a mandate or play-or-pay plan, a large portion of those costs are going to be borne by the individuals that you are trying to extend coverage to. Wages will adjust, prices will adjust, things will happen. But you cannot pass on prices forever. The example of the fast-food people across the street, if you raise the price of hamburgers, fewer hamburgers are going to be bought. And one of those fast-food places may well go out of business.

So, the jobs are lost in that way. In terms of the range of costs, one of the things we did is that you can present not only economists but actuaries with the same data set, and they will come up with different numbers because they have to make assumptions.

So, we tried to come up with a very broad range of what the plans would cost so that the truth is somewhere in the range, even though the range may be so large that you may find it difficult to use in making policy decisions. And that is essentially what we did.

Senator ROCKEFELLER. But, do you understand what Mr. Sheils is saying? You see, the stakes are very high here. If you say that 900,000 jobs plus, under one scenario, are going to be lost, do you understand the impact of that on those of us who vote for any of these things or against any of these things?

I mean, this sort of range business is very risky. In other words, you are protecting yourself, in a sense, but the stakes are very high here. And Mr. Sheils is saying that he does not approach this with the idea that the unknowable is, in fact, unknowable. And, in a sense, you are.

You are leaving yourself an enormous amount of wiggle room, but, in the meantime, throwing out some terrorizing information on the political landscape which is having an effect on people.

Dr. CUSTER. Well, I leave myself the wiggle room because, in fact—you have had a lot of numbers thrown at you, you understand—these numbers are based on assumptions of how people are going to behave, assumptions of what costs are going to be. The assumptions drive those numbers.

Senator ROCKEFELLER. But you did not do cost-shifting. You did not do cost containment, did you? You did not include them.

Dr. CUSTER. Well, they are included implicitly in the range of the cost of the plans.

Senator ROCKEFELLER. Would you agree with that, Mr. Sheils? That is, that he included cost containment and cost-shifting?

Mr. SHEILS. Well, if you included cost containment, it would really not change our—our estimates of employment loss were for the initial year of the program. They reflected the costs that you would find in these initial years.

Employment loss would increase over time if you do not control costs. That is clear. If you control costs, then you get your effect and the effects of this thing will pretty much stabilize.

But there has been a lot of talk about the need of the problems of stabilizing the play-or-pay program. It is unstable unless you put in those cost containment provisions, and provisions that have teeth in them. A lot of the nightmare scenarios do materialize without that.

But, in any health reform system, single-payer, leaving the system alone, there is going to be a plethora of nightmares unless we control cost.

Senator ROCKEFELLER. But the Labor Committee output is now what we accept as Biblical. It is not the pre-Labor Committee.

Mr. SHEILS. All right.

Senator ROCKEFELLER. It is the Labor Committee output. The cost containment is hard, it is there, it does justify—I do not do numbers—your 260 down to net 215 cost savings.

Mr. SHEILS. It largely evaporates without it, and I know that there will be a lot of pressure to eliminate it. It is important to keep in mind that a lot of the concerns that have been raised will materialize if it disappears.

I would like to suggest that we change the way we think about the job loss just for a minute, just to gain a little perspective on it; 63,000 people. That is the high range of the estimate that is very much consistent with some other leading authorities' figures on this have suggested. That is a lot of people, Senator. That is a football stadium full of people; a lot of votes.

But we have to look at it in the context of tradeoffs. What are we doing here? We might lose tens of thousands of jobs. But we will see tens of millions of people get insurance coverage. A quarter

of the uninsured are children; we will see children get their coverage.

We also see many thousands of families today ruined financially, wiped out by health expenditures in excess of their ability to pay for it, underinsured and uninsured persons.

We estimate that there are about 1.9 million families in this country under age 65 who will experience health spending in excess of 30 percent of income. Under this program, the number of families who find themselves in that circumstance is reduced by 40 percent; 700,000 families.

Now, the job loss potential is small, but real. But the benefits from this program are large, and they, too, are very real. And we have to deal with these very difficult tradeoffs that the Congress is going to have to make in looking at this.

Dr. CUSTER. I would agree with that. I would echo that, if I could, that, in fact, what we tried to do is to draw out the fact that you are going to have these costs—there is no such thing as a free lunch—to get these benefits, and it is up to society and Congress to decide how those tradeoffs should be balanced.

Senator ROCKEFELLER. All right. So none of you will starve, on my watch. Let me end, John Motley, with you. I was very moved by your statement in response to my first question, and I was glad that I was moved.

That is what I wanted to be, and it struck me as an enormously genuine statement on your part about the fear that people have. There is no question in this whole mix that the people who have to fear the most are those that have the fewest employees.

I mean, that is a given. Chrysler wants single-payer. They do not have to pay anything that way.

Well, one of my fears has always been—although, I repeat, I would take single-payer over the next 10 years over what we now have. I would prefer that to sort of going on the way we have, coming up to the edge.

And, remember, health care is not that old a discussion. It is for the folks sitting behind me, but for those of us in the Congress, like trade, it is a fairly recent discussion.

You want to see this happen, you said your people want to see this happen. And the costs of not having it happen are enormous. So, all I want to say to you, John, is I terribly want to work with you and NFIB and other small business groups.

The stakes are so high in this that what I am trying to say is that I hope that we can work with an idea to make this work for small business. In HealthAmerica new, small employers—would not have to provide coverage for 2 years, tacked onto the 5 years before implementation was phased in.

If we do not succeed in our efforts, we are going to have a single payer system handed to us by the American people, along with our heads. It will be better than what we have got now, in my judgment, because it will have cost containment.

Health reform will upset a lot of people, but it will provide stability. Even physicians and hospitals, in my judgment, will operate better under the certainty of what is going to happen than the lack of certainty that happens now.

I do not, however, want that to happen. I want something, and it does not have to be pay-or-play precisely, but it has to be something that is more workable and more comfortable within the American context.

But if you and I can kind of agree that we keep working in good faith at trying to make this work for small business, that we do not want small business to get shattered by this, remembering that small business is the most vulnerable. In the Pepper Commission, you remember, we proposed 40 percent tax credits for a period of 5 years for small business.

Under our bill, the 25 percent tax credit was permanent. And there are a whole lot of other things we do in our bill which people do not talk about much. I mean, we take into consideration the self-employed, the self-incorporated; all issues that affect millions of people.

So, I agree that based upon your reaction to my first statement, which I thought was a very moving reaction, a very honest reaction, and a very accurate reaction, small business has an enormous amount, along with others, to lose if we have a health care meltdown which I think we are in a position of having.

But I think that is what is happening. We can try and work this out, and kind of the automatic response from my part—for example, one of your witnesses here, I was harsh. In my judgment, I was too harsh. I was confrontational. I was in a bad mood, or something. But I was harsh. But that damages things. That damages things because that sort of hardens NFIB; that hardens me. That is not what we need here, like Senator Riegle was talking about. I think we have to work this out.

NFIB has a very powerful position in health reform. You have a lot of sway in what can happen. Ninety-four percent of your people do not like what is happening under pay-or-play.

It is true, also, that a lot of businesses may not understand the benefits of our proposal, or they may not know that we can, in fact, make more adjustments as we mark this up to make it more acceptable to small business.

So, it is really in that spirit that I want to close this hearing and any comments that you might want to make.

Mr. MOTLEY. Well, thank you, Senator. I want to make just a few. I think we certainly do agree with your sense of urgency, with your sense of need to do something.

That, very frankly, is one of the reasons that we gravitated very quickly to the bill that the Chairman of this committee introduced because we thought in the political context that was one of the few things that had an opportunity to move. We do have physicians which differ on some things with the rest of the business community, such as capping the deduction, which most of the rest of the business community would not.

We did send a letter around to the Senate which pointed out many of the good things that you did have in your proposal. We have one problem, and that one problem I think we are aware of, and that is the employer mandate which is in there.

I was tempted at times to jump into the argument between my two very esteemed colleagues on either end of the table here, but decided that I had better not. Except that I do have one problem

in all of the discussion about cost containment and the shifting of costs.

It seems to me that the arguments made for savings can only be made from employers that provide health insurance today, and I think we all agree that there are tremendous savings involved, and they will benefit.

And that is why cost containment is an extremely, extremely important part of this. In fact, if we do not have cost containment, the rest of it does not work, period.

But I still am terribly, terribly concerned about those small employers out there. In our membership, we have a higher percentage as a whole.

I think Senator Bentsen before quoted some statistics that only 33 percent of the employers with 10 or fewer employees provide health insurance.

Those are the people that I am worried about, and I would go back one more time to the foundation study that we did in 1990, which is the thing, I think, that catapulted us into this debate.

And we asked a simple question there. It said, the NFIB foundation reported that if employers were mandated to contribute $150 per month per employee for health insurance, 26.4 percent would get out of business, and 23.9 percent said they would let all their employees go and continue operating.

Now, that is a hurdle that I have. That is a hurdle that NFIB has. We not only think it is not good for small business, we do not think it is good for the American economy. We think it creates problems on the other side of the equation. I mean, we have to take care of those people some way. We very much want to continue the discussion, we very much want to work with you and the rest of the members of the committee.

In most of the speaking I do around the country on this issue, the one statement that I start out with is that the status quo is no longer acceptable. And I think, probably, we all agree upon that.

But that is a very unusual position for the American Main Street business community to take, because they definitely prefer the status quo on most things. So, I would very much like to continue to work.

We have been involved and had many, many discussions with you in the past. Some of the ideas put forward by Blue Cross/Blue Shield here today are extremely interesting to us. Mr. Enthoven's ideas are extremely interesting to us, and we would like to continue to pursue them.

Senator ROCKEFELLER. I will say something that will surprise you, perhaps. Two or 3 years hence when we complete health reform—and I think that is when we will do it—I would not be shocked if one of the final tradeoffs would, in fact, be what you almost suggested, and that is a tax cap for an employer mandate. Now, if you suggest this provision to the average Democrat, he would run screaming from the room. But I am just saying that we all must be flexible.

When you are confronted with a public policy issue this big, people, as Senator Riegle has said, have to come to the table and be prepared has to give up something in order that all can survive. Surviving is in everybody's interests, including the smallest of

small businesses. At some point, without compromise, the whole issue can be overwhelming us and won't get solved.

Mr. MOTLEY. Yes. Like Bernie, who testified just before I did, we would, I think, agree that one of the things you have to take a look at is capping the deduction for businesses, but also capping the tax-free transfer to the employee. It has to be done on both sides.

Senator ROCKEFELLER. Well, that may happen, and it may not. None of those things are ruled out in my mind, because the crisis is too great.

Mr. MOTLEY. As part of the final solution. I think it is going to take us awhile to get to that point.

Senator ROCKEFELLER. Yes. We need a spirit in which—everything is on the table. As far as I am concerned, there are only two restraints. There has to be universal coverage and there has to be rigid cost containment.

Outside those two conditions there are all kinds of variations that can take place. I just hope that as we proceed, we will keep talking and drive towards the goal.

Now, having said that, I really thank all of you. You have been kept well beyond when any reasonable discussion should end, but you have been very, very helpful. There will be further questions. I did not ask a quarter of what I wanted to ask. I really thank you, and our hearing is adjourned.

Mr. SHEILS. Thank you.

Mr. MOTLEY. Thank you.

Dr. GRINER. Thank you.

Dr. SHEA. Thank you.

Dr. CUSTER. Thank you.

[Whereupon, the hearing was concluded at 1:10 p.m.]

COMPREHENSIVE HEALTH CARE REFORM AND COST CONTAINMENT

WEDNESDAY, JUNE 17, 1992

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

The hearing was convened, pursuant to notice, at 9:35 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Baucus, Rockefeller, Daschle, Breaux, Packwood, Danforth, Chafee, Durenberger, and Hatch.

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

The CHAIRMAN. This hearing will come to order. Please cease conversation as we get underway here.

This morning we continue to examine proposals for comprehensive reform of the health care system. We find millions of Americans are finding health cost unaffordable now. And the problem is steadily getting worse.

In 1992, over $800 billion will be spent on health services in the United States. That figure will double by the year 2000.

This series of hearings is to help the Finance Committee find solutions to these challenges. Across this country, people are looking for assurance that they will have access to affordable health care.

Reaching an agreement on the game plan is going to be tough because there are many complex issues involved, but we have to meet that challenge.

The hearings today and tomorrow will focus on two contrasting approaches to health care reform, those that would establish universal health insurance coverage through State and federally-based public programs and those that would use the Federal tax policy and other incentive-based methods as a means of providing Americans with access to affordable health insurance.

Originally, we had planned to discuss only the public program field today and the tax incentive proposals tomorrow.

However, the visit of President Yeltsin requires that Senator Kassebaum appear today. She will be in Kansas with him tomorrow. Also, Secretary Sullivan asked to appear today, and we are accommodating that request.

We have had four bills referred to the Finance Committee, suggesting a public program approach to health care reform. Almost 1 year ago, Senator Bob Kerrey introduced S. 1446, the Health USA Act of 1991.

Earlier this year, Senator Paul Wellstone introduced S. 2320, the Universal Health Care Act.

And then Senator Tom Daschle, a member of this committee, joined by Senators Wolford and Simon, introduced S. 2513, the American Health Security Plan.

Just last week, Senator Inouye introduced S. 2817, the National Health Care Act of 1992.

Every one of these calls for a dramatic change in the health care program of this country.

We will hear testimony from those that believe that nothing short of a fundamental overhaul will work to give Americans access to affordable health care.

But others argue that we can achieve this change without the disruption that is associated with replacing our current health care financing based largely on employment-related health insurance coverage.

Last February, President Bush presented an outline of his health care plan. And a key feature of that is a series of tax credits and deductions to assist individuals in purchasing private health insurance.

While we have seen the statutory language for other pieces of the President's plan, we are still waiting for the details of this part of the proposal and legislative language.

Among our distinguished witnesses today is the Secretary of Health and Human Services, Dr. Sullivan, who will discuss the President's health care plan.

The President and others have proposed these plans as a means of preserving as much as possible of our current system of health care financing while addressing the lack of universal access and rising health care costs.

Yet serious questions have been raised about the ability of these approaches to guarantee every American access to health insurance and get skyrocketing health care costs under control.

Our lead-off witness this morning is Senator Nancy Kassebaum who will discuss S. 2346 which she introduced in March. Ms. Kassebaum's BasiCare approach would maintain reliance on private health insurance, but proposes significant changes in that system, including regulation of insurance premium increases.

After that, we are going to hear from Senators Bob Kerrey and Paul Wellstone who will present their proposals to the committee.

Because Senator Inouye is chairing another hearing this morning, we will submit his statement for the record.

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

The CHAIRMAN. Following Secretary Sullivan's testimony, our final panel of expert witnesses includes both proponents and opponents of the public program approach to health care reform.

So I am going to be looking for guidance. And I know the members of the committee will want to hear from these witnesses as to how we can ensure affordable health care access for all Americans.

Senator Packwood, any comments you might have.

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

Senator PACKWOOD. Mr. Chairman, thank you.

As we go through these hearings, it is clear there are a few varieties of health plans. You can encourage people to buy insurance one way or another and hope that you get universal coverage.

Or perhaps you can compel, as Senator Kassebaum does, individuals to purchase insurance.

You can go the employer plan and mandate insurance coverage; Hawaii does—there employers have to provide coverage. They cannot opt out and pay a tax and have the government pick up some of the costs.

Or you can go the single-payer plan route. The one it is mostly compared to is Canada where with a few exceptions all health insurance is wiped out as we now know it and the government becomes the payer. Call it what you want.

The plans vary a bit as to what they cover. In some cases, there are some co-payments and in some cases deductibles.

The question on that I would ask is this. Our health expenditures this year, public and private will be about $809 billion. The Federal Government currently is paying about $230 billion, $230 to $240 billion total.

So you have roughly $570 to $580 billion of additional cost that the Federal Government is not now paying, assuming we were going to pay all costs that we are not now paying.

I know the arguments about the GAO Report and how much can be saved by going to a single-payer plan. The Congressional Budget Office reduces that and its estimate is about half the size.

But if you took the GAO figures, it is around $70 billion, and subtracted that from the additional 570, you are down to $500 billion in additional Federal expenditures.

I am fully aware that employers would no longer pay health insurance premiums. Someone else would buy health insurance, but you are talking about a major shift of payment from somebody to somebody.

And in fairness, those who advocate the single-payer plan with the government paying ought to include in it how do they plan to pay for it. If you did it totally with a payroll tax, it would be a payroll tax of about 28 percent, counting current Federal expenditures.

If you did it with a combination of corporate and individual income taxes, it would be immense increases. I mean, in excesses of 100 percent increases in the income taxes for corporations and individuals.

So I would hope that the witnesses would give us an indication of how it would be paid for and not just slough it off by saying: Well, there are going to be efficiencies and people will no longer buy health insurance.

That is fair enough, but somebody is going to pay taxes. And before we get into a single-payer system, I think we ought to know who this somebody is.

Thank you.

The CHAIRMAN. Senator Kassebaum, we are delighted to have you. If you will proceed.

STATEMENT OF HON. NANCY LANDON KASSEBAUM, A U.S. SENATOR FROM KANSAS

Senator KASSEBAUM. Thank you, Mr. Chairman.

I very much appreciate being able to testify today, rather than tomorrow. As you acknowledged, Senator Dole and I are going to show President Yeltsin some wheat harvesting in Kansas tomorrow.

Because this hearing was billed originally as a hearing on the single-payer plan, I would just like to reiterate that my legislation is not a single-payer plan. I will try and be brief, as you have many testifying.

I have spent months, as many of us have, in trying to sort through the health care issue. My first priority was that I felt the reform package had to have a strong cost containment mechanism. To me, that is the heart to achieving any significant health care reform.

Secondly, we had to have a financing mechanism. We just could not put something forward without saying how we were going to pay for it. That incidentally is one of the reasons why my bill ended up in the Finance Committee.

Third, I did not believe in mandatory requirements on employers. Trying to find something that was simplified, without Federal micro-management, and with strong cost containment was what guided me in putting together my proposal.

If I may, Mr. Chairman, I am going to run through the basic parts of my legislation I will also be glad to respond to questions, although I know time is of the essence.

First, my legislation will simplify the insurance market around a single, uniform basic benefits package that every private insurer must offer and that every American will carry. I call this package BasiCare.

No insurance company will be permitted to offer any non-BasiCare plans that duplicate BasiCare benefits. They may, however, sell supplemental policies for persons wishing additional coverage.

Second, the content of the BasiCare package will be determined by an independent commission patterned after the current military base-closing commission. Congress will have the power to vote up or down on the Commission's recommendations, but not to amend them.

It seemed to me that if Congress tries to get into determining exactly what benefits are in the package, we will never be able to adequately address the health care crisis before us.

Third, BasiCare will be subject to strict insurance rules protecting beneficiaries from discriminatory rating and underwriting based on health status.

Fourth, rising health care costs will be contained by placing binding annual limits on the maximum allowable rate of increase in the BasiCare premiums. This will be determined annually by the commission.

This mechanism of cost containment will force insurers to work with providers in negotiating efficient systems of health care delivery. They may offer BasiCare packages below that annual ceiling, but they cannot go above it.

This cost-containment structure establishes the most efficient and integrated network of health delivery, but not by means of which we ourselves try to lay out every sign post along the way. Rather, what we do is lay out a framework and force the private sector to negotiate within it.

Fifth, health care coverage for the uninsured will be addressed by offering low-income persons direct, public vouchers for the purchase of BasiCare policies. This will incorporate Medicaid.

Sixth, Medicare will be assimilated into the BasiCare plan over a 10-year period. Both Medicaid and Medicare will eventually become part of BasiCare. Ultimately, we will all be carrying the same package of basic benefits.

The BasiCare commission will be the authority to structure this transition. Mr. Chairman, as you certainly recognize, that will not be an easy thing to do, but it can be done. And I believe for the long run, it is greatly important that it be done.

Seventh, long-term care coverage will be included in this BasiCare package. I believe this is very important, Mr. Chairman. I realize the difficulties, the actuarial problems associated with this, and the potential financial costs. However, I believe my children should have to carry long-term care coverage in their benefits package, it should not just be those who reach age 65 who begin to worry about whether they should have long-term care insurance and how to pay for it.

If we spread out the cost of long-term care coverage over a broader population, it will help us pay for it in the long run.

Eighth, financing for this legislation will be obtained from three sources. One, a limited draw funds from the current Social Security payroll tax, not to exceed 1 percent of that tax. One percent equates to $56 billion in 1996.

I believe there is strong justification to use up to 1 percent of the currently collected payroll tax. As we face the need for long-term care, for example, I think this use of payroll tax revenue will be beneficial to all.

The second financing piece will be a limit on the current 100 percent tax deduction and exclusion for employer health benefit contributions. Such deductions and exclusions will remain at 100 percent, by will be limited to the cost of the BasiCare package.

Any additional health benefits an employer might offer would not be deductible; only the cost of the BasiCare package would be deductible.

Finally, financing for my plan would be supplemented by the appropriation of existing Medicaid expenditures.

This legislation also includes malpractice reform, significant expansion of community-based primary care services, and measures to increase the number of health professionals in under-served rural areas.

I would like to conclude, Mr. Chairman, by stressing that whatever course we adopt on health care reform, I firmly believe it must be comprehensive.

There has been a great deal of talk about incremental approaches and moving ahead with aspects of reform many of us could agree on. Small business insurance reform initiatives are a good example.

However, if we miss an opportunity to deal with the more difficult issues, such as cost containment, financing mechanisms for access expansion to uninsured, and long-term health care, then I think we have missed an opportunity to draw both the more easily resolved issues and the more difficult resolved issues together.

All of this is not easy Mr. Chairman. You clearly laid out, as did Senator Packwood, the difficulties we face with this. However, I am convinced that if we continue to discuss and examine the complexities of these initiatives we can come up with a comprehensive bill.

I would like to add that my co-sponsors are Senator Rudman and Senator Burns. And in the House this legislation has been introduced—with some modification regarding prescription drugs—by two Democrats, Congressman Glickman and Congressman McCurdy, and a Republican, Congressman Pat Roberts.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator. Are you both going back to the same markup?

Senator KASSEBAUM. Pardon?

The CHAIRMAN. Are you both leaving here to go to a markup?

Senator KASSEBAUM. Yes, we are, but I will probably have to get back before Senator Wellstone. He has left his proxy. [Laughter.]

The CHAIRMAN. Well, I was about to keep you as a panel, but with that, I will not. All right.

Senator KASSEBAUM. Let me just ask if my full statement could be made a part of the record?

The CHAIRMAN. That will be done.

[The prepared statement of Senator Nancy Landon Kassebaum appears in the appendix.]

The CHAIRMAN. Let me ask you a question. You are talking about preserving the market approach on insurance and as I understand it, combine that with a tough, regulatory process to hold down the premium.

How do you keep the insurance companies, the ones who are being squeezed on the premium, from cutting back on the quality of care?

What we often get from consumer groups when we talk about managed care is: Well, when the squeeze comes, they just cut back on quality.

And in a turn, how do you respond to those that will be testifying: Well, let us cut out that middle tier; and let us save that cost; let us just go let the government administer the whole program?

Can you respond to those two questions?

Senator KASSEBAUM. Let me start perhaps with the last comment. I just feel we are increasingly becoming more micro-managers regarding Medicare. My legislation will go in the other direction, for example, will have just one single form that needs to be filled out.

I think when we hear from consumers and providers and insurers, it is the paperwork that they talk about. It is the micro-management that can indeed hurt quality just as much.

So I think we have to simplify. I think we have to be continually mindful of quality. And that is something you have to wonder about in any plan, whether it is federally regulated or whether it is being handled more in the private sector.

The commission, the independent commission that is established under my plan, has significant authority and would, of course, be a full-time commission which would monitor the system.

Also, you will have such large numbers in this system because everybody is in the system that you are going to have both the insurers and the providers working together for their own best interests to make sure it is working at a high level of quality.

You obviously are going to have some winners and losers. For some people because they are low risk, payments are going to be higher and maybe for fewer benefits.

You are certainly going to have others at the other end of the spectrum who will have more coverage for less cost. So, I think whenever you are trying to deal with this, as you know, there are winners and losers.

But I think overall what we are trying to establish in a significant way is the means of controlling spiraling costs and not losing quality.

And it will take some vigilance. I will grant you that. But I would rather start without trying to cross every "t" and dot every "i" from the Federal regulatory standpoint and hope that this broad parameter will accomplish what we would desire.

The CHAIRMAN. One comment. Medicare is administered by the private insurance companies under the direction of the Federal Government.

Senator KASSEBAUM. But significant direction from the Federal Government.

The CHAIRMAN. And I must say with some gain. Let me state that because the costs of Medicare have not increased to the extent and the percentage that you are saying is happening in the other part of the private sector.

Are there further questions of the Senator?

Senator DANFORTH. Mr. Chairman.

The CHAIRMAN. Senator Danforth.

Senator DANFORTH. Senator Kassebaum, we have had numerous meetings both in the committee and among Senators on the whole question of health care.

And I have reviewed your proposal, and not only reviewed it, but asked constituents to look at it. And the response that I am getting is very, very favorable.

I think this is really the soundest and most balanced single approach I have seen to what we should do about health care.

And my one question to you is is your list of co-sponsors closed with Senators Rudman and Burns? And if not, would you accept one more? [Laughter.]

Senator KASSEBAUM. I would certainly be honored to do so. You would be a valuable co-sponsor. Thank you. I will do that forthwith. Maybe I should leave while I am ahead.

The CHAIRMAN. It sounds like you have a good exit line there, Senator. [Laughter.]

Senator DASCHLE. Mr. Chairman.

The CHAIRMAN. Yes, Senator Daschle.

Senator DASCHLE. Mr. Chairman, I would just like to compliment Nancy as well. She has made a major contribution as Senator Danforth has indicated. And she has thought through many of these

questions very thoroughly. And I commend her for the contribution she has made.

I am a little unclear with regard to access in terms of the suggestion that I thought you just made with regard to vouchers.

Were one not to have access to those vouchers, does one then not obtain any care? How do the vouchers work? Are they provided to everybody who cannot pay any type of a premium?

Senator KASSEBAUM. Yes.

Senator DASCHLE. So you guarantee universal access in that regard?

Senator KASSEBAUM. Yes.

Senator DASCHLE. Okay.

Senator KASSEBAUM. Those who are uninsured would have vouchers, 100 percent for those below the poverty level and phased support for those up to 200 percent at a minimum. You just cannot cut it off at the poverty level for those who do not have health insurance. I think there has to be some phase in for that. And those cost figures run from $30 to $40 billion, as you know.

Senator DASCHLE. So the vouchers are made available to anyone. I guess it is on a graduated basis, going up to a certain income level, made available based first upon income and I guess second upon family size and other factors that would determine their eligibility for the program.

And one could make a commitment through that regardless of circumstance, the vouchers would ensure universal access?

Senator KASSEBAUM. That is right. To Kansans who say, "Why should we pay for those who do not have insurance? Why should we worry about the uninsured?" I would say, we are paying for that now. And it is far better for us to spread that cost out, and to deal with this up front. And that, in part, is why I thought it was important to have a financing mechanism clearly included in the legislation.

You cannot talk about vouchers for care if you do not have strong cost containment features.

Senator DASCHLE. The second question would be, as you describe your plan, it appears that it is similar in many respects to the Medicare program.

And I know that sometimes painting anything by saying it is like Medicare is the kiss of death. And I do not want to do that to your well thought-out plan, but as the Chairman said, there are some advantages to Medicare.

The administrative cost is 4 percent. In the private sector, it is now about 16 percent administrative cost on the average. Some are even higher than that.

But you do work through the private sector in contracting to provide that particular care in a certain area. The difference is, as I understand it, you do not contract with business, you just mandate that the BasiCare plan be made available to all of those who are clients of that particular company. Is that correct?

Senator KASSEBAUM. No. What is mandated is that everybody has to carry it. An employer does not have to offer to cover for their employees. I would assume, and one would hope that they would.

And as a matter of fact, I think it would be something that would be appealing to business because you have a basic care package at lower cost.

Also, employers under my system are not going to be continually in negotiations for what should be covered or not covered under health care. This does not mandate that an employer must carry insurance for their employees.

Senator DASCHLE. So if you have an employee who earns, say, $20,000 a year and the employer has chosen not to provide that coverage, the employee has passed the voucher threshold?

Senator KASSEBAUM. That is right.

Senator DASCHLE. So if he wants insurance, he has to buy a plan from one of these companies. Is that correct?

Senator KASSEBAUM. That is right.

The CHAIRMAN. Any further questions?

Senator ROCKEFELLER. Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Mr. Chairman, all I want to do is to compliment Senator Kassebaum.

As Senator Chafee and I know very well, one of the things that is really needed in the Senate and in the Congress is people who have different approaches towards health care reaching out to each other.

I read your effort to be a deeply serious, a deeply purposeful, deeply thought through effort, including cost containment.

Some provisions I might or might not agree with, but the point is you have set out to try to be helpful and constructive in the process. And I really value that.

One of the things that I worry about around here is that what people are for is their first choice. And then if there is a second choice, well, they are against that because it is not their first choice.

What I see in you is the spirit to try to reach out to bridge this gap between the different approaches. And I honor that. And I respect that. And I want you to know that.

Senator KASSEBAUM. Thank you.

Mr. Chairman, well, I think all of us testifying here this morning would clearly feel that way. I think there are parts of all three of our packages that have some similarity and some differences.

I would just say, Mr. Chairman, I have sometimes wondered, as I wandered into this whole health care reform issue, why one does it, because it does become so complex. And you think you have solved one problem, and you have only created three others. But out of this, I am convinced that we will put together something that will be useful.

And I appreciate being able to testify this morning.

The CHAIRMAN. Thank you very much, Senator.

Senator CHAFEE. Mr. Chairman.

The CHAIRMAN. Yes.

Senator CHAFEE. I just want to join in complimenting Senator Kassebaum.

I understand how the basic package is set up and that there is a limit on future cost increases. Maybe it is tied into the Consumer Price Index or something like that.

But in any event, the next question that arises is would the insurers have a tie-in with the doctors and the hospitals like the Alain Enthover arrangement so that they would have some system of controlling costs?

Senator KASSEBAUM. The thrust of the system I am proposing to create would be much of what Dr. Enthoven has spoken about, that is, moving towards managed care or integrated networks of care.

I think that is inherent in what you would have to negotiate to put a beneficial product together as an insurer under my system.

Senator CHAFEE. That essentially is your cost control mechanism, is it not?

Senator KASSEBAUM. That is right.

Senator CHAFEE. One, the insurer would only pay "x" dollars.

Senator KASSEBAUM. That is right. And let me just add, Mr. Chairman—and I do not want to take too much time—that there have been many who have worried about balance billing by providers.

While it is not written in the legislation now, I certainly would consider putting in language that a provider must accept as full payment and reimbursement whatever he or she has contracted in their insurance plan. There cannot be that additional balance billing.

Senator CHAFEE. Thank you very much.

The CHAIRMAN. Senator Baucus has a comment he would like to make.

Senator BAUCUS. I, too, Nancy, thank you for your very valuable contribution h re.

As I understand it, you have the basic package to provide basic care. And then for those who wanted supplemental care, they could have supplemental coverage. Is that correct?

Senator KASSEBAUM. Yes. There can be any kind of additional coverage, but it cannot be a competing BasiCare plan. And any self-insured group let me say, too, can continue to self-insure, but that plan has to be a plan with all the requirements that BasiCare has.

Senator BAUCUS. How many additional policies do you contemplate under this scheme?

Senator KASSEBAUM. Who knows.

Senator BAUCUS. But a good number.

Senator KASSEBAUM. Well, maybe or maybe not.

Senator BAUCUS. Yes. And a question that comes to my mind is this. What is to prevent the commission, because of scarce dollars, from reducing the provisions in the basic package which will encourage many more people to buy supplemental insurance and therefore tend to defeat the goals that we are striving for here?

Senator KASSEBAUM. Because under my bill there has to be coverage for basic hospitalization, catastrophic, and preventive care. Now, that is a pretty broad basic benefit package.

Let me add, because we are phasing in Medicare within a 10-year period the BasiCare package is probably going to resemble in many ways many of the benefits that Medicare covers.

The CHAIRMAN. I know the Senator is trying to get to her markup.

Senator BAUCUS. I know. And I apologize.

I am just concerned that this is a concept like most of these that sound good, but to some degree evade some of the basic problems that we are going to have.

And I am concerned about a two-tiered system in this country under this approach. That is pretty bothersome.

Thank you.

Senator KASSEBAUM. Thank you very much.

The CHAIRMAN. Thank you, Senator.

Our next witness will be Senator Wellstone who also shares the same problem of trying to get back to that markup.

I would ask all the Senators, myself included, to limit any questions to 3 minutes at the most.

Senator Wellstone.

STATEMENT OF HON. PAUL WELLSTONE, A U.S. SENATOR FROM MINNESOTA

Senator WELLSTONE. Thank you, Mr. Chairman. And I thank Senator Kerrey.

Let me first of all say that I think that the challenge for us now in the Senate is to move from the discussion of health care as a problem or even as an issue to sound public policy that will make a difference in the lives of people. That is clearly the challenge.

Now, I start with a proposition, number one. And the proposition that I start with is that the health care system is in CRISIS—all spelled in capital letters—or in critical condition if you want to be clever with words.

And frankly, I think there is pretty broad agreement on that. I have met with Stuart Butler from the Heritage Foundation. We do not agree on a lot of issues, but I think we do agree on that question.

Therefore, if you start with that proposition we are talking not about incremental change, but we are really talking about rather significant change, fundamental reform in the way in which we finance, administer, and deliver health care.

I think it is very important to get that proposition straight.

There is a second proposition that I want to lay out, because I think this is a value question and I think we are now getting closer to agreement on values.

Each and every citizen deserves the best quality, most dignified, humane health care regardless of income, employment status, age, region of the country, or current or prior health care condition. That is terribly important.

Now, after having laid forth those propositions, let me move forward and talk about the particular bill that I am here to discuss today, S. 2320, the Universal Health Care Act. I thank you for this opportunity.

I want to mention that Senator Simon and Senator Metzenbaum are also co-sponsors of this bill. And there are some 70 members in the House of Representatives that have signed onto it.

I am going to outline this bill. And I am going to start by saying that I think the key challenge in making sure care is available is cost control.

People do not wake up in the morning and look in the mirror and say to themselves, am I liberal, am I a conservative, am I this or that?

What they say about health care is, can we have some kind of health care system in our country that will provide me with some reassurance that I will be able to afford decent coverage for myself, or for my children, or that my grandchildren will be all right?

Now, I am not going to go through the litany of problems because we have all heard that. I just simply want to make one other compelling point. Health care, national health insurance, universal health care coverage in some form has become a political majority issue.

The economics of health care have moved it away from being a low-income issue to an issue that affects the vast majority of people in this country. And I do not think I need to tell members of the committee why or how because I think you have heard that before.

The huge advantage of the single-payer health care bill has to do with cost control. In many ways I find it ironic that the bill that calls for the greatest structural change I think is the most fiscally conservative.

And I believe there will be no major reform bill passed by the United States Senate unless we have effective cost control.

This bill, 2320, the Universal Health Care Act, is strong on cost control for the following reasons. Number one, it does simplify and streamline the administration and financing of health care. That is terribly important.

There is a world of difference—ask consumers and ask providers—between coming in with a card and getting coverage, and having to fill out all the forms to get paid.

And from a provider's point of view, it would be a great relief not to have to constantly watchdog consumers and and fill out endless forms to make sure people pay.

There is a world of difference when you do not have 1,500 different insurance companies, with all sorts of rules and regulations. Instead, you streamline the administration and financing through single-source funding. That is my first point.

My second point is one that I think we have to consider seriously, Mr. Chairman, as we try to figure out our common ground.

As I look at national health insurance issues comparatively speaking, I think the evidence is close to irrefutable, those countries that have done well have established some kind of concentrated public authority to balance the power of providers.

That is where I think some of the sort of pro-competition models fall short. And I think what you have with a single-payer system, which by the way is administered at the State level if States so desire, is you have a public authority that can negotiate global operating budgets, can negotiate capital budgets.

It is terribly important, as we think about the principles about health care in this country, that we build in not only universal coverage and not only comprehensive benefits, but also, Mr. Chairman, we have to build in some structure of accountability.

There has to be political accountability. Irrational cost shifting does not work. The government financing it and then saying to the private sector, "Fill in the check." does not work.

The real strength of a single-payer system is that you have this concentrated public authority that can be a counter weight to the power of providers. That is the second point.

The third point is on cost control. I believe this is absolutely critical to the consensus that we might reach.

We put a very strong emphasis, Mr. Chairman, in our package of benefits on preventive health care and primary health care.

I want to make the point in as eloquent way as I can that I think not only is this the right thing to do, not only is this the humane thing to do, but I think there are enormous cost savings.

There are going to be some interesting studies coming out that I think are going to point to that. My own experience was two parents with Parkinson's Disease.

I just have to tell you I wish we had had more support for home-based care as opposed to, at the very end of their lives, it having to be institutional care.

Let me go on with just a couple of other points. And then I will conclude. I think that another key thing about single-payer is that on the one hand, it is very strong on cost control with single-source funding, but it enhances consumer choice.

It is within the pluralistic framework. The government is involved in the financing, but you do not have government-run nursing homes, government-run hospitals.

Consumers can choose HMO's, or fee for service. You have existing private-public sector all within a pluralistic framework, all at a decentralized community and State level, which I think is hugely important.

I want to speak to Senator Packwood's question. I think there are two points to make conceptually in response to Senator Packwood's question, which I can fill in with numbers if you so choose.

Number one, we will pay for services differently. We will pay far less on administration. And that money instead will go into direct provision of services for people.

And number two, we will pay for health care in a different way. No question about it.

We will see an increase in public sector expenses, but we will see a decrease in private sector expenses.

I would argue that as we look at where we are right now to the year 2000, there will be huge savings, according to a variety of different estimates I have seen, for the business community, for all of us, which I think is terribly important if we do not want our health care system to bankrupt this economy.

I also would like to say that if you cost this out, I can safely say to the vast majority of people in this country that with a single-payer, universal health care coverage, you will pay no more out of pocket than you do now, and perhaps you will pay less. There will be much more bang for the buck and the services will be much more comprehensive.

Finally, Mr. Chairman, there is enormous and concentrated economic power opposed to this, but I have to say that we are talking about an issue which ultimately presents a real challenge to the Senate.

Are we going to have a system of democracy for the few or democracy for the many?

I think health care really puts all of us to the test. We ought to be able to pass in the U.S. Senate and the House of Representatives a comprehensive, universal health care coverage program regardless of what kind of economic interests are opposed to it, because the vast majority of the people are calling for it.

The CHAIRMAN. Senator, in your proposal, as I understand it, you totally replace the private insurance program and substitute a public program for it.

And I know that there are many, many Americans enthusiastic about that approach, but there are also a lot of Americans that have a deep concern about looking to the government solely to run the health program for our country.

How do you respond to that?

Senator WELLSTONE. Well, let me respond in a couple of different ways. First of all, Mr. Chairman, I think it is very important to point out that the single-payer would be administered at the State level.

States could contract out to insurance companies which would not do the underwriting, but could administer the programs, if States so desire.

My second point is that in the negotiations that take place at the State level between the single payer and the providers, consumers would be involved. I think a lot of decisions are made right now in managed care about who gets coverage, who does not, with no voice for consumers.

A whole lot of decisions are made by insurance companies that write the rules of the game almost to the point, Mr. Chairman, where for all too many citizens, you have to prove that you will never use health insurance in order to be able to obtain it.

This would be out in the open, public negotiation and bargaining. And I think quite frankly, that is the way we should fashion and develop health care policies.

My final point is that I do think—because I think your question is an important one and a profound one—that one of the real challenges for those of us who really believe we have to move in this direction is to deal with, if you will, the ambivalence that people have about government involvement.

I would simply say in this particular case what the polling evidence shows is that while people are not sure of the exact proposals, people have reached the conclusion that there are certain decisive areas of life in the United States of America, like education and like health care, where it is appropriate that the public sector really has a major involvement.

The CHAIRMAN. Let me say to the members of the committee who have arrived late that Senator Wellstone has a markup he is trying to get to. So if you would take that into consideration as you are asking questions.

Senator DASCHLE. Mr. Chairman.

The CHAIRMAN. Yes, Senator Daschle.

Senator DASCHLE. Mr. Chairman, I want to commend our colleague from Minnesota for an excellent statement and for the work he has done on this issue like his predecessor who has just testified, Senator Kassebaum. He, too has made a major contribution.

I think you asked an excellent question. I would ask Senator Wellstone whether or not another answer besides the good one that he just gave might be that we have a vote on repealing the programs, the government-sponsored health care for those who already have it in our society.

Forty percent of Americans have government-sponsored health care today. Let us have a vote in the Congress on taking away all veterans health care. Let us have a vote on taking away all Indian Health Service health care. Maybe we will have a vote on all Medicare health care.

The chances are if a vote were to be taken on any of those programs, the overwhelming sentiment expressed by Republicans and Democrats alike is that, no, those particular people ought to continue to get veterans health care, Indian Health Service, Medicare, Medicaid.

And it seems to me if we have already demonstrated that for that segment of people this is a very important contribution to health care, we have to ask ourselves what is it that they have that the other segments in this society do not want? What is it that they are willing to fight for?

I just spoke to the VFW last weekend. And the single, most important thing on the VFW agenda this year is protecting the VA system.

They said, "I do not care what else you do, do not take our veterans health care away. It is absolutely essential that we retain the identity and the system as it exists today."

Here you have veterans, the hard core patriots of our Nation fighting for a system that we are led to believe nobody else wants. And it is sort of a paradox that I think is worth exploring.

But I think the Senator from Minnesota probably gave the best answer, but it occurred to me as you were answering that there is another answer. And I just thought I would lay it out for the record.

Thank you for your contribution, Senator Wellstone.

Senator WELLSTONE. Thank you.

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

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. Senator Wellstone, you are one of the cosponsors of the companion bill to the Russo bill, the Senate bill.

Senator WELLSTONE. It is very similar.

Senator PACKWOOD. You mentioned cost. I want to ask you if this is roughly the way you would pay for it?

This is the way Congressman Russo pays for it, but I want to emphasize that he was basing this on 1989 cost. And he estimated that we would need $411 billion in additional revenues. That would be more like $570 billion today.

But for the moment assume the $411 billion. This is the way he pays for it. One, increase the employer health insurance tax rate from its current 1.45 to 7.5 percent and eliminate the wage cap.

Two, eliminate the wage cap on the employees' health insurance tax. It would not raise the rate, but it would eliminate the cap. So to begin with, we shift it over tremendously toward employers.

Three, it would impose the health insurance tax on the remaining State and local government employees.

It is a battle we have gone through perpetually, but it would make the States pay the 7.5 percent that the employers pay. It would keep 1.45 on the employees.

It would require a State contribution of $85 per resident and 85 percent of State Medicaid spending to the Federal Government. It would increase the Part B premium from $31 to $55 on seniors.

It would increase the corporate income tax rate from 34 to 38 percent. And it would increase the personal income tax on all incomes over $40,000 for couples and $20,000 for singles.

Although, I might add, the House already used that up in the tax bill they passed that was vetoed. So assuming that had not been vetoed, you would have had to go higher on that.

And lastly, it would increase the tax on Social Security benefits from its current 50 percent to 85 percent if you go over the threshold.

Is that the way you finance your bill?

Senator WELLSTONE. Similarly, yes Let me go through it real quickly, Senator Packwood. I would be pleased, by the way, to give you a detailed account of this.

[The information follows:]

FINANCING FOR THE UNIVERSAL HEALTH CARE ACT OF 1992

Employers

- Imposes payroll tax of 6%
- Eliminates the current cap of $130,200 on wages subject to current 1.45% Health Insurance (Medicare) tax (employer share)
- Increases top corporate income tax rate from 34% to 38% for businesses with over $75,000 in profits

Non-elderly individuals

- Personal income tax increases

Currrent bracket	New bracket
15%	15%
28%	30%
31%	34%
	38 for family >$200,000

- Eliminates the current cap of $130,000 on wages subject to current 1.45% Health Insurance (Medicare) tax (employee share)

Elderly Individuals

- Part B premium
- $25 a month for elderly above 120% poverty
- If currently taxed on Social Security benefits due to outside earnings, tax increases form 50% to 85%

States

- 85% of current state share of Medicaid expenses
- Per capita tax of $85 a year for each state citizen

Federal Government

- Same dollar amount currently contributed

Senator WELLSTONE. Two points. Number one, I feel very strongly—it kind of goes to part of what Senator Danforth's statement on the floor of the Senate was about yesterday.

I feel very strongly that we cannot introduce legislation unless we are willing to talk about how we finance it. And then once you do that, that opens up the debate.

We do impose a payroll tax of 6 percent. We do raise the corporate income tax. And these are the primary sources of funding. And in addition, we do raise the income tax code progressively.

We have some additional ways of raising revenue which we have spent a lot of time discussing with senior groups and others, Senator Packwood.

Now, my own view about this is it is far better to cost it out. And that is why I said to you earlier, that conceptually, it is absolutely clear. I do not think people in this country are in the mood for any of us to talk of—it is like to use an old Yiddish proverb, "It is like trying to dance at two weddings at the same time."

You can't say to people we should have a universal health care coverage or national health insurance and then say to people you can do it without financing it. Of course, we move more to public sector expenditures.

But I want to say again, Senator Packwood, that what you will see is two things. Number one, far less in private sector expenditures.

Number two, a lot of the premiums that people are paying right now are taxes. There are taxes. That is what people are paying, by the way, for something far less than comprehensive coverage.

And finally, if we do not want to see 37 percent of GNP spent for health care by the year 2030, we are going to have to put into place an institutional arrangement to control cost.

My argument once again is that I believe the evidence is rather irreducible and irrefutable that single-source funding is the best way to do that.

Senator PACKWOOD. I find you very courageous to admit it. I can find very few people that support the Russo that will own up to the taxes that are going to pay for it. You left out a couple in here.

Senator WELLSTONE. Well, I have it all. I will give you the detailed account.

Senator PACKWOOD. That is fine. I will take your word for it.

Senator WELLSTONE. Sure.

Senator PACKWOOD. We are talking about whether or not the Federal Government would be more efficient than the private sector, whether or not we really would have fewer employees and less overhead, and administer something with absolute effectiveness, I question that.

Senator WELLSTONE. Yes.

Senator PACKWOOD. But even assuming that because Congressman Russo assumes those savings and so came up with these taxes. I do not think many people have been faced yet with, "I did not mean that" in terms of paying for this.

Senator WELLSTONE. Well, Senator, let me be real clear. I know the Chairman is anxious to keep moving on. And I do not want to take any more time, but let me just make a couple of quick points.

Whether it is the GAO study you mentioned or whether it is the CBO study or whether it is a series of articles in the New England Journal of Medicine, I think there are two points to be made. And

that is why I wanted to be very forthcoming with your question about revenue.

I could argue that from administrative savings alone, you could cover the uninsured and underinsured, but the point is we are talking about other benefits that are not included right now.

Long-term health care costs have to be covered. I think it has got to be included in universal health care coverage. In addition, prescription drug costs have to be covered. I told you the package of benefits was tilted toward preventive health care and primary health care.

Again, I believe this is the direction we have to go in. And what I say to people in Minnesota and what I say to people around the country is, one more time, of course, we pay for it, but we pay for it in a different way.

You pay out of your left pocket or you pay out of your right pocket. But when you pay out of your right pocket and you have single-source funding, it is not health care costs skyrocketing and skyrocketing and skyrocketing, it is comprehensive, it is universal.

And now you have what you have been asking for which is some reassurance that you will not have to worry about health care costs that affect yourself and your children.

The CHAIRMAN. Are there further questions of the Senator?

Senator BAUCUS. Mr. Chairman.

The CHAIRMAN. Yes, Senator Baucus.

Senator BAUCUS. Very briefly. Senator, does your plan fold in Indian Health Service, the VA system, CHAMPUS, Medicare, and all these programs together or not?

Senator WELLSTONE. The VA system is kept separate.

Senator BAUCUS. Indian Health Service.

Senator WELLSTONE. I think that is kept separate, too.

Senator BAUCUS. And the CHAMPUS system is also separate?

Senator WELLSTONE. Yes.

Senator BAUCUS. And the reason why you do not include those? I mean, if you are going to single payer, why not go single payer?

Senator WELLSTONE. The reason that we do not include those is that in discussions with a variety of different people about it, is partly that it just became clear that people consider these programs very important. It is partly because of what Senator Daschle said, Senator Baucus.

With the Veterans Administration and also Indian Health Service, you have people who consider themselves to be in like an absolute battle to preserve what they have. And my perception was that they felt somehow this would take away from what they already have.

Senator BAUCUS. I only ask. I am struck when I am home the number of times veterans walk up to me and they are very dissatisfied with the VA system because they do not qualify, either they are not sufficiently service connected or their incomes—they are not paupers so they do not qualify. And it is a problem. Frankly, a lot of veterans have expressed that.

Senator WELLSTONE. Well, I agree with that.

Senator BAUCUS. Thank you.

Senator WELLSTONE. Can I just very quickly say, Senator Baucus, and to Senator Bentsen, I appreciated the opportunity to speak here today.

There are changes we will make. And some of these questions I think have to be looked at. Also, there is a question that was not raised which is people that lose their jobs in the insurance industry.

Where is the economic diversification? How do you deal with that? Where will jobs be created?

I mean, this is not heaven on earth. There are imperfections. We have to keep working through some of these questions. Our mental health section is not good enough. And I think you raised a very good question.

The CHAIRMAN. Thank you very much.

Senator DURENBERGER. Mr. Chairman, may I just ask that my statement be a part of the record?

The CHAIRMAN. That will be done.

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

Senator DURENBERGER. And I compliment both of my colleagues. I compliment my colleague from Minnesota who has leaped into the toughest issue we have with both feet, both hands, all of his muscular body. [Laughter.]

He was 6 feet tall when he was elected. [Laughter.]

And I know that his enthusiasm speaks for itself.

And particularly my colleague from Nebraska who I admire so greatly. I remember his volunteering to come to the Pepper Commission meetings, even though he was not on it, and sitting through all those meetings with us.

With all due respect to some of our colleagues, when I watched some of the Democratic candidates debate—particularly in the debate that our colleague from West Virginia chaired up in New Hampshire—our colleague from Nebraska was the only person who first had a health care reform plan and then actually laid it out in front of a national audience and then submitted himself to questioning before people who probably did not know the first thing about it. He was very honest and very direct in his response to the consequences that might come from the adoption of his plan.

Senator KERREY. It is a real winning issue, Senator. [Laughter.]

Senator DURENBERGER. I must say, I like our former colleague's plan a little better than I like yours, but I wanted to say for the record that both of you are to be complimented for having the courage of your convictions.

Senator WELLSTONE. Thank you.

The CHAIRMAN. Thank you very much.

Are there any further questions?

[No response.]

The CHAIRMAN. Thank you very much, Senator.

Senator WELLSTONE. Thank you very much, Senator.

The CHAIRMAN. Senator Kerrey, we are very pleased to have you. We are looking forward to your statement.

STATEMENT OF HON. J. ROBERT KERREY, A U.S. SENATOR FROM NEBRASKA

Senator KERREY. Thank you, Mr. Chairman and members of the committee.

I have a statement that I ask your consent to be a part of the record.

The CHAIRMAN. That will be done.

[The prepared statement of Senator J. Robert Kerrey appears in the appendix.]

Senator KERREY. I would like merely to summarize the proposal Health USA that I and Senator Moynihan are co-sponsoring and then to focus on the likely impact that a proposal like this—and there are others that are similar. I listened to Senator Kassebaum's proposal. I talked to her earlier.

It seems to me that there is in the midst of all the various proposals some growing consensus on the need to control cost, the need to address particularly the growing price for entitlement programs in our own deficit, the need to provide universal coverage.

There is it seems to me some consensus there. And I would like to focus on that deficit portion.

In summary, Health USA is a State-based system. It provides comprehensive and uniformed benefits for all Americans. It is a pay-as-you-go proposal. It is publicly financed. However, it is private health care.

And there is competition both in the delivery system of health care itself and there is still competition in the delivery of either insurance or health care plans in the private sector.

My view is indeed that one of the central arguments is what can government do well or what does the private sector do well?

And we ought to make certain that we have the private sector do those things well that it can. And we have to provide an environment in particularly where competition can continue to move towards reduced cost and to increase quality of care for Americans.

I have, Mr. Chairman and members of the committee, struggled as I suspect lots of you have as well to try to get my arms around details of the cost. I have been told that we have spent $800 million this year. That is the current estimate.

And when one tries to break that down in the various expenditures, it is difficult to come up with a firm number.

We get different numbers from CBO than we do in the green book. It is difficult to be terribly precise.

I have attempted for myself and for the members of the committee to break down all expenditures that we are making both from the Federal Government and State and local government and in the private sector to try to illustrate what would happen if you put in place a pay-as-you-go system as a principle.

Simply saying essentially that if we want to provide a health care benefit with any tax revenue, whether it is an increased program or with the current program—if you want to provide a benefit to Americans for health care, we should pay for it.

We should not sell bonds. We should not debt finance health care benefits. That is a principle that is a part of Health USA. And I am prepared to argue it with the people in my State that that ought to be a part of any reform package that in the end is passed.

We spend, Mr. Chairman, about $21 billion a year through all of the agencies of the Federal Government, FDA, the Block Grant Program, vaccine programs, health professional loans, Indian Health Service, CDC, NIH, and various other expenditures at the Federal level.

I can provide the committee—in fact, I would ask that these numbers as well be a part of the record.

Senator KERREY. In addition to that, Mr. Chairman, we spend $131 billion for Part A and Part B Medicare. Those are checks that are cut out to providers as the committee is well aware of. And we spend the Federal share, $72 billion. Now, this is 1991 and 1992 expenditures estimated for this fiscal year.

The Veterans Administration, we will spend $13.7 billion. For Federal employee health care benefits, we spend $14 billion. In the Department of Defense for health care, we spend $14.4 billion.

We will spend approximately $265 billion this year for health benefits. We will pay and write checks and hire people in various agencies to provide health care of different kinds.

To pay for that $265 billion, we have one source of revenue. And that is Medicare. As the committee is very well aware of, we do not actually collect dollar for dollar every Medicare check that we write.

We do not fully fund Part B. But for Part A and Part B, we generate about $105 billion worth of revenue. That is all we are collecting.

We are writing $265 billion worth of checks. And we collect $105 billion worth of revenue. Now, the difference between those two is approximately $161 billion.

Under the current method of financing our government, we deficit finance about 28 percent of everything that we spend.

So it can be fairly said that the source of revenue for our $265 billion is $105 billion of Medicare premium, $132 billion of general fund taxes, all sources, and a $40 billion bond sale, $40 billion worth of additional debt that we will acquire this year to pay the bills for health care.

My proposal and others that are similar that insist upon pay-as-you-go would have an immediate impact in that we would say we are going to pay for all of our expenditures with current revenue.

Now, it would force a debate. I can go home once I have achieved consensus that we are going to have pay-as-you-go and say, well, we can cut $40 billion if that is what you would like, but one way or the other, we have to pay for our expenditures for health care with current dollars.

There is an assumption that I have in my proposal. And it does indeed force a rather interesting debate once you get to the method of payment.

In addition to that, Mr. Chairman, there are also some savings because I am proposing in my proposal that we cap the rate of growth under the Federal programs at the rate of inflation.

And I will provide the committee as well the potential savings in that regard if you simply say that the growth of the Federal programs will remain at the rate of inflation.

It is difficult under current situation at times to make the case that we get real deficit reduction with health care.

I am arguing that one of the reasons that we have a difficult time of doing that is that the general public is not aware of how much additional debt we acquire every single year just to pay for health care bills.

In other words, if we did not add any additional programs, do not pass Health USA—which is unlikely I would observe in this current session of the Senate—do not pass any comprehensive reform, if all we did is simply say we are going operate under the assumption that if we are going to have doctor and hospital bills paid that we should not sell bonds to do it, we have got to close the $40 billion expenditure gap just to get that done.

It is difficult to make the case therefore that comprehensive reform, such as Health USA, is going to reduce the deficit, but the principle argument that I continue to make as an advantage of the system.

I also advantages in the system in that we will have positive incentives for people to prevent illness, sickness, and disease in the first place. There will be positive incentives on the financing side for us to look for revenue sources that will help us do that.

There will be positive incentives as well for individuals to do the right thing out in the work place. We have 31 million Americans who next year will go to a welfare office to get health care benefits.

Fifteen million Americans who are out there working full-time earning less than $10,200 a year.

All of us have seen the damage that is done when we provide an incentive for Americans to go to the welfare as opposed to remaining in the work force.

There are positive incentives that will occur as a consequence of putting this kind of a universal package in place.

But the biggest short term benefit I believe for us will be that we will be able to make immediate substantial progress on reducing this Nation's fiscal deficits.

The CHAIRMAN. Senator, that is a very interesting break down and I think some additional for us that is quite helpful.

Actually in 1993, the projection of the tax expenditure for health care is $53.6 billion.

Senator KERREY. What is that?

The CHAIRMAN. Just a little question of definition. So it is $53 billion for 1993 and estimated to go to $80 billion by 1997. That gets the numbers a little closer to yours, Senator.

But as I look at this, you have some difference from a pure single payer and you are giving some flexibility to the States. So I would assume a State could go to single payer, pure and simple, with the government administering it all; or I suppose it could go to managed health programs, too. It would be that kind of flexibility. Is that what you are saying?

Senator KERREY. Yes. It is unquestionably a managed model. It encourages the development of managed care, but by making it a State-based system, I am assuming that the Federal Government does not do a very good of delivering health care.

I mean, one of the assumptions that I have in the proposal is that when it comes to describing the details for procedures, we would be well advised to allow inside of I think the continued movement for the development of procedural guidelines.

It would be wise for us to allow the specific delivery systems to be developed by the States themselves. I think one of things that you, Mr. Chairman, have focused a great deal of attention on that we struggle to do under the current system is to try to solve the growing problem of rural health care delivery.

There is not a uniformed response. There is not unlikely to be a uniformed solution. And under the current model, we have got to get the Health Care Financing Administration to practically approve a systemwide and nationwide change.

And what I am proposing is the States would have a considerable amount of flexibility inside uniformed benefits to do that.

The CHAIRMAN. Are there further questions of the Senator?

Senator DASCHLE. Mr. Chairman.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. I was just going to commend Senator Kerrey for his testimony and for the work he has done as well. I think he was the very first of any of our colleagues to introduce health care legislation.

And it has been used as a means of comparison with virtually every other bill that has been introduced. And I certainly commend him for his leadership.

He has, in response to the question of the Chairman, indicated the advantage to a certain extent already of a State-based system.

I happen to believe a State-based system is ultimately the only way that we can address the problem nationally, given the tremendous differences that exist throughout our country and the inadequacies of attempting to administer a national program from Washington.

But I would like, if you could, Senator Kerrey, you to elaborate a little bit more on what you see to be the real advantages of a State-based system.

Senator KERREY. Well, to me the advantages of a State-based system our that you can stipulate that you are going to have budgeted health care at the national level and that we are going to have a pay-as-you-go system so that you got a shared responsibility in that kind of environment, at least specifically in that regard.

In 1991, the State and local governments will spend about $136 billion for health care. We will spend $266 in 1992. These numbers as you know, Senator, change so rapidly it is hard to get firm numbers. So I apologize for not having an estimate for 1992 State and local.

State and local cannot sell bonds to pay for bills. So the State government under the current environment has rapidly growing costs for Medicaid as more and more people understandably in my judgment move from a work place where they do not have health care or they are underinsured, move into the ranks of welfare.

They are having growing cost for the Medicaid program. They have to do pay-as-you-go. So If I can stipulate that we have a pay-as-you-go system, you got a true partnership then with the State and the Federal Government.

Under a State-based system, once you get to the managed care decision, States are much more likely it seems to me to be able to make in a way that satisfies the quality concerns that people have

for health, the detailed protocol decisions that very often have to be made.

It will provide us with an opportunity immediately to do interstate cooperations. May I proceed? Nebraska and Wyoming, Nebraska and South Dakota, Nebraska and Colorado, Nebraska and Minnesota, Nebraska and Iowa, Nebraska and Kansas, doing cooperative ventures where all they have to do is just contact one another and reach an agreement much in the same way that we today with higher education.

Today, we cannot do that. We have got to come back to the Health Care Financing Administration in Maryland and get permission from the Federal Government to be able to do that.

So under a stipulated system that has in it a pay-as-you-go method, a stipulated system as well that says that we are going to budget the health care, I think a State-based system as opposed to a federalized system of decisionmaking is far preferable from a qualitative standpoint.

The CHAIRMAN. Thank you, Senator Kerrey. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

Bob, just to set the framework for a question, let me tell you what I believe in the larger context and that is one of the things that we all believe in is equal access. And we believe in getting the highest quality care we can.

We believe doing that in some way through a system of universal coverage. And some of us would add universal coverage of financial risk, which describes the parameters of the subsidy system we would have to put under this.

I happen to believe that the universal coverage of the financial risk part of it is basically an income security problem which ties in with jobs and a lot of other things.

That is a responsibility this committee ought to be discharging and this government ought to be discharging.

Now, the question deals with the issue of cost containment because that is the driving question around here.

I want to quote something from the Secretary's comments, who is coming up next. I will ask him the same question.

He says, "The President," meaning President Bush, "believes that individual's health care involves very personal decisions; consequently, he also believes that the government should not interfere in peoples' choices or treatment options. The government should not restrict opportunities to take advantage of the best health care in the world."

I happen to believe that we cannot tell who is the best. There is a U.S. News out there on the stands today telling us which are the best hospitals in the judgment of some physicians.

But I think part of the heart of our problem in America today is that if we know that the Mayo Clinic or the University of Nebraska Medical Center are the best, then we ought to be sending them all the business.

Do not send your heart business to somebody who is not as good as some team in Omaha or in Rochester or some place like that. And yet, we have not figured that one out yet. We are spreading our money all over the place.

The reason Mayo is so good is they do it right the first time. You do not have to come back a second time or a third time or something like that. That is where so much of the waste in the system comes from.

I have not figured out how in this committee we could pass a piece of legislation that gets the quote, cost containment benefit of sending everybody to the Mayo Clinic.

But my question concerns your feelings about how much we can legislate in this area of cost containment and how much we need to give leadership to the private provider community to start demonstrating who does what best with the least amount of money, and then start sending our business to those people?

Senator KERREY. Well, first of all, I think the Mayo Clinic is an excellent example of the kind of operation we should be trying to create incentives to the development of that kind of center. It is low-cost relative to many of the centers.

And it is surprising for people to make that discovery because very often what happens in the debate about health care is that people assume that if you have low-cost health care, you are not going to get high quality.

They say, "Oh, well, Senator, you want to budget health care which is the principle way you are going to control cost, you say you want to have a pay-as-you-go system of health care, thus you are going to restrict access in some fashion."

But the fact of the matter is that we see many examples of very high quality health care occurring in an environment of fiscal responsibility and high efficiency.

One of the problems that we have, and I know, Senator, you have seen it as I have, is reflected in my movie that I cite from time to time, "Tin Men", where Richard Dreyfuss walks into a Cadillac dealership and offers to buy a Cadillac.

And the guy says after he has loaded it up with options, "How much do you want to pay for it?" And Dreyfuss says, "The truth of the matter is, I do not want to pay anything for it."

Well, unfortunately and regrettably, that is the way we are with health care. That is the way my attitude is. I want a Cadillac. If you ask me how much I want to pay for it, "Well, not much." And that is for me. I am even worse with my own children when the demands are greater.

So what I believe we have got to do is have a very simple declaration that we are going to say our health care system is going to be pay as you go, to say that it is morally wrong for us to borrow money to pay doctor and hospital bills, just as a principle, a simple principle to drive into the current before you ever get to reform.

Although, I believe it will encourage us to advance reform even further because Americans will discover that government is already involved heavily in health care, making detailed decisions.

I appreciate the Administration saying they do not want to get involved in health care decisions. I would assume that based upon that principle that they would reverse some of the previous decisions that they made directed doctors not to provide certain information to their patients.

We have a great deal of government involvement today in health care. The question for us really is what can government do well?

Let us have government do the things that it can do well. And let us have the private sector do those things that it can do well.

And I am perfectly willing to have that argument. Indeed, I think we need to have that argument in the current system. Again, whether you have reform or not, I think we should encourage competition.

We need to encourage innovation out there. We need to reward people for preventing illness, sickness, and disease.

I did not spend a great deal of time on quality today, but I want to provide a financial system in America where people begin to ask the question again, "What can I do to get you healthy? How can I make Senator Kerrey healthy?"

Today, the rewards do not flow to individuals who either ask or try to answer that question.

The CHAIRMAN. Thank you. Are there any further questions?

Senator CHAFEE. Mr. Chairman.

The CHAIRMAN. Yes, Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

I think Senator Kerrey has made a very interesting presentation—particularly his point that we are not paying currently for the system. Now, we are borrowing.

I believe you said $40 billion of total Federal expenditures is currently being paid for.

I think that is worthwhile to point that out because many are saying, "Come up with how you are going to pay for it." Well, we are not paying for it now.

I was also interested in your point about cost sharing. It is a different point from what others have raised here. I think in the Senator from Minnesota's presentation, he did not mention cost sharing.

You have a 20 percent co-insurance and under certain circumstances I believe you except preventive medicine and hospital services.

So I think you have made a very valuable contribution here. And we look forward to studying it more as we go along. I want to thank you.

Senator ROCKEFELLER. Mr. Chairman.

The CHAIRMAN. Yes, Senator Rockefeller.

Senator ROCKEFELLER. Thirty seconds.

Senator Durenberger made reference to this, but Senator Kerrey was elected in 1988. And virtually one of the first things he did—that was about the time that the Pepper Commission was starting up.

He came and he said that he would like to audit. And he attended much more than most of the commissioner members did.

And to say that he saw an issue early, not because of any political consequences, simply because if the substance of the issue, he went out and mastered it. And then he just did not go with the conventional wisdom.

He devised his own approach, but then he did not devise it and spring it. He took it back to the people of his own State and went through as I understand scores of meetings with all kinds of small businesses, large businesses, people of all kinds, all across Nebraska.

And then only after he had tested it at the consumer forum, so to speak, brought it back and presented it to the American people with great force and great passion.

So it is an extraordinary thing that Senator Bob Kerrey has done in this country, really quite an extraordinary thing, nothing like it that I have seen in terms of a single-purpose effort on the part of a single, very capable person.

So I am profoundly proud to serve with him as a colleague.

Senator KERREY. Any more compliments? [Laughter.]

Senator KERREY. I got a lot of time. [Laughter.]

The CHAIRMAN. No. I think Senator Rockefeller has pointed out something that is quite singular about your effort and much deserved.

Any further comments?

Senator CHAFEE. I would say that he is——

The CHAIRMAN. You had better leave while you are ahead, Bob.

Senator KERREY. I will. Thank you. [Laughter.]

The CHAIRMAN. Mr. Secretary, we are delighted to have you.

I am sure that you have found this discussion interesting and that it shows something of the intensity of interest and the concern about this very major issue facing our country.

STATEMENT OF HON. LOUIS W. SULLIVAN, M.D., SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY KEVIN MOLEY, DEPUTY SECRETARY

Dr. SULLIVAN. Thank you very much, Mr. Chairman, and to the members of the committee. Thank you for inviting me to address the important issue of health care reform with you.

I am accompanied by Deputy Secretary Kevin Moley from the department.

I want to share with you the President's commitment to a health care system for the future that attacks cost-driving incentives and that ensures access for all Americans.

The President is committed to preserving, for all Americans, the best of our world-class health care system.

We are prepared to work with you, Mr. Chairman and members of the committee, to quickly enact practical reforms that will make a real difference for Americans.

The President's Comprehensive Health Reform Program provides effective solutions that address the concerns of all Americans, be they businesses, consumers, State or local governments, and others.

Cost shifting, inefficient delivery of care, and waste are all tackled, head on, in the President's program.

Soon, we will be submitting legislation that would reduce the waste-inducing incentives in the current malpractice system.

Yesterday, we delivered legislation that attacks waste and inefficiency in the paperwork and information handling process for health care.

If all the cost saving strategies mentioned in the President's plan were implemented, Americans could see a savings of nearly a trillion dollars by the end of this decade.

Through implementation of a combination of reforms that include revisions in the private insurance and tax systems—which form the

centerpiece of the President's plan—Americans can quickly gain the benefits. The goals which the President is determined to achieve, include the following: Guaranteed access to health insurance for all poor families through a system of credits with which individuals and families can buy needed coverage.

Second, availability of affordable coverage for all Americans and choices that will be of high quality and good value.

And third, a rational and stable private system in which individuals can change jobs without fear of losing their coverage due to health conditions, and where individuals do not have to worry about a denial of coverage because of health status.

In addition, the President's plan calls for: modernization of our public Medicaid system; promotion of prevention and the role of personal responsibility; elimination of underlying factors that continue to drive up costs; and elimination of State-mandated benefit and anti-coordinated care laws.

So the message I wish to leave with you today, Mr. Chairman, is the President's strong belief that any system of health care reform cannot rely on a centralized, top-down system. That would stifle choice and innovation.

The President believes an individual's health care involves very personal decisions, as noted by Senator Durenberger. Consequently, he believes that the government should not interfere in peoples' choices or treatment options.

The government should not restrict opportunities to take advantage of the best health care in the world.

If our Nation adopted systems based on either the pay or play concept or price fixing or national health insurance, the President and I both believe that diminished quality, restrictions, and increased rationing would be the outcome.

The situation today in government-controlled systems is decidedly not the outcome that Americans are expecting from reform of the health care system.

Let me illustrate. In Britain today more than 1 million people are on waiting lists for medical treatment and some wait for more than 2 years for elective surgery.

In Canada, under pressure from a global budget, hospital stays are 70 percent longer than in the United States, not because the patients are sicker, but because the system encourages hospitals not to release recovering patients in order to admit new patients which are expensive-to-treat.

Canadian doctors, according to a recent report, are deeply concerned about their ability to get access for their patients to special care and medical technology.

In addition, let me report, a large majority of doctors in Canada and Germany also believe their systems require major overhaul.

The approach to health care reform based on free markets and tax-based incentives proposes a very different role for government: one that helps rather than hinders American citizens and small businesses.

The President offers straightforward solutions to attain his goals through a decentralized, market-based system that is sensitive to individual choice and community needs.

These are good, workable solutions for getting Americans affordable health care. Solutions which do not rely on the top-down, centrally controlled system favored by others such as pay or play or national health insurance.

In conclusion, the President's program proposes specific, commonsense measures that target and correct current problems while building on the strengths of our current system.

Eighty-six percent of Americans today have coverage. They want affordable coverage that is dependable. The President's plan would achieve this. Those currently without insurance would, under the President's plan, have access to their choice of affordable health insurance and mainstream medicine rather than a government-run, one-size-fits-all program.

At a time when many American products and services have problems competing in the world's market place, our health care system, in terms of quality and innovation, is second to none.

Preserving our world-class system will benefit all of our citizens. Using existing strengths as a building block, we can make corrections that make health insurance available and affordable for our citizens without bringing more disruption, intrusion, and government waste into our citizens' private lives.

This Administration, Mr. Chairman, would be delighted to work actively with the Congress to make available to the American people a workable health care plan founded on market-based principles, quality, and individual choice.

Thank you.

[The prepared statement of Hon. Louis W. Sullivan appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Secretary. Mr. Secretary, it appears to me that the core of the President's proposal is using the tax code as an incentive to get people to buy health insurance.

And I am sure in your career of medicine you have pursued things a lot more interesting than the tax code, but I would like to ask your reaction to the way it appears to me that this works.

Now, if you are talking about a tax credit and you are talking about low income individuals, as I understand the proposal, that in effect would pay for all of the health care costs for low income people. Then when you get to a little higher incomes and you get to the choice between a deduction and a credit, you begin to get a different result.

That is particularly true if you are looking at a deduction. So if we get into that type of thing, let us look at the value of that deduction. If you have a family of four with an income of between $21,000 and $50,000, you are talking about a 15-percent tax bracket. They would get a deduction worth about $550.

Now, if you get to those making more than $50,000, most of those are in the 28 percent bracket, then you get almost twice as much. Instead of $550, you get $1,050 for that family.

According to the Joint Tax Committee, you have about 59.8 million tax returns in the 15-percent tax bracket that would get a maximum of $550 out of the President's proposal. Yet most of those, 27 million higher-income taxpayers, would get almost twice as much.

How can you justify that much higher a subsidy for higher income people who probably need the assistance less than lower-income people? How can you justify that kind of differential for higher-income people?

Dr. SULLIVAN. Well, certainly, that is a very good point you make, Mr. Chairman. And what we have crafted is a proposal that indeed does build on the tax system.

This is not fixed in concrete. If there are better ways that we could address that in working with the Congress, we are certainly open to working with you to see what could be done to address that.

The CHAIRMAN. I can assure you, Mr. Secretary, if anything comes out of this committee, if I can influence it to that effect, we will not have a twice as big subsidy for folks of higher income as we do for those of lower income. I really see a serious inequity in that kind of an approach.

Dr. SULLIVAN. Certainly, the President's proposal represents a beginning to assist not only the low-income individuals, those at the Federal poverty level or below, but certainly provides help for middle-income individuals.

We are not saying that the President's proposal is a perfect one, but what we are saying is that it is better than what we have now. It does provide assistance. And using the tax system, yes, it does pose that kind of situation.

But clearly, if there are better ways that this can be approached and have this paid for, we certainly would want to work with you in achieving that goal.

The CHAIRMAN. I am encouraged to hear that, Mr. Secretary. I see my time has expired.

Senator Packwood, do you have any comments?

Senator PACKWOOD. Mr. Secretary, a couple of days ago we had the Governor of Hawaii here and his director of State health.

He went through his plan in Hawaii that they have had since 1974, which is an employer-mandate play only plan. There is no pay. You cannot opt out of it.

There are some people that are not covered, the part-time employees, insurance and real estate sales people on partial commission, but for those, they are covered by a State insurance plan. And they have the same level of benefits as those who are covered by the employer.

We quizzed him extensively about is there something different about Hawaii: Is it the climate, are people more healthy, or is there a younger work force?

And his State Director was excellent. They had good studies saying, "No. We are not significantly different." The argument that there is sort of a moat around them does not distinguish them as different.

We asked him if mandated insurance coverage had deterred the attraction of business, has it hurt business? And he said, "No. It has not done that." They are still attracting business.

"We asked what is wrong with the kind of a system which guarantees the coverage? He said when they started, their health costs were comparable to California. Now, per capita, they are about 60 percent of California's.

Insurance companies are continuing to come, but they have to bid on a common package. The competition is between the insurance companies to offer the best plan they can that guarantees the benefits.

What is the matter with that approach?

Dr. SULLIVAN. Well, Senator Packwood, it so happens that my Deputy, Mr. Moley, met with the Governor of Hawaii yesterday. And we talked with him about that. So I would like to have him comment, please.

STATEMENT OF KEVIN MOLEY, DEPUTY SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MOLEY. Well, Senator Packwood, I did not have the opportunity to have as an extensive conversation as you obviously did. But in meeting with the members of the National Governors' Association yesterday, we, in fact, did spend considerable time talking health care delivery.

And a couple of things I would point out with respect to Hawaii and the Governor's comments yesterday in our meeting.

One is that they do still have some considerable concerns about their system in Hawaii, one of which reflects concerns of a number of other Governors about ERISA, the fact that many corporations coming to Hawaii are covered under ERISA and consequently you are not covered under the benefit program of the State.

But secondly, and I think it is an important——

Senator PACKWOOD. That I might add is a legitimate concern, but it is no fault of their health plan.

Mr. MOLEY. That is correct. But it reflects the fact that they still have problems in respect that all is not perfect.

But the other thing I think is maybe more important—and I will like to have further discussions and based on what you have said here today—is by virtue of the nature of industry in Hawaii, which is very service oriented, they do have a tremendous number of part-time employees, that is employees who are working under 20 hours a week who consequently are not covered under the statewide plan.

As a consequence, we do think there are some significant differences.

Senator PACKWOOD. They are not covered under the employer plan.

Mr. MOLEY. That is correct.

Senator PACKWOOD. But they are covered. And the same insurance companies bid on administration of their coverage under the State plan, it is privately administered.

What I cannot remember is whether the State funds it somehow through taxes or if it is funded by the employers of the private plans.

Mr. MOLEY. Right. There are payroll taxes associated with it. And therein comes the larger rub in respect to ERISA. But quite frankly, we would like to follow up with them and earn more before responding further.

One thing I might mention, however. Although we are not supporting a mandated program, a straight play program, from the President's plan you could get to a mandated program.

From either pay or play or some of the other national health care systems that have been mentioned, you could not go back to a mandated system.

You could get there from the President's plan. You could not get there from pay or play.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman.

Mr. Secretary, much of your argument for the President's plan is based upon the belief you again expressed this morning that government should not interfere with peoples' choices for treatment options. Is that correct?

Dr. SULLIVAN. That is correct.

Senator DASCHLE. How does that correlate to the Administration's position on the gag rule?

Dr. SULLIVAN. Mr. Daschle, the Administration's position is that for physicians in family planning clinics, the government does not intrude in that discussion. The gag rule issues refer to non-physicians.

The guidelines that the President has directed me to implement were in response to the previous criticisms suggesting that we were interfering with the doctor-patient relationship.

We are very sensitive to that. So we have implemented rules that would not interfere with that. So those who are unhappy with the guidelines now, have transferred their unhappiness to other health professionals.

Senator DASCHLE. Well, I do not want to use my time to argue that particular issue. I think I could spend the entire doing just that because I disagree somewhat.

Would it not also follow that we are interfering peoples' choices or treatment options with an array of governmental health programs today, the Indian Health Service, the Veterans Administration, Armed Forces health care, Medicare and Medicaid?

Do we not set out criteria by which the choices of care, the treatments provided are all to a certain extent regulated through Federal policy?

Dr. SULLIVAN. They are regulated only in the sense of appropriateness and quality of care, not decisions on what the care will be.

And let me also comment, Mr. Daschle, on one of your discussions with Senator Wellstone previously concerning the VA system, an example of where we believe government intrusion really interferes with efficiency and good medicine.

You will recall that Secretary Derwinsky of the Veterans Affairs Department and I had proposed a pilot study to utilize under-utilized veterans' hospitals in remote, rural areas that did not have other health care services for Medicare and Medicaid beneficiaries.

And as you know, we were directed by a vote from the Senate of 93 to 3 not to proceed with the demonstration involving two VA hospitals out of a total of 172.

Now, everyone tells me this is good policy, this is good efficiency, this is good medicine, and this is appropriate, but politically this is not something that the Senate would want to do because of the concern of the veterans' lobbies.

The veterans' lobbies have misinterpreted the intent of this because Secretary Derwinsky and I both believe that this in the long run would preserve the VA hospitals.

By having under-utilized facilities with the VA population, by the year 2000, becoming much smaller, there is going to be pressure that you and your colleagues are going to have to meet with the budget stringencies that we have.

That is a good example of where politics gets in the way of—where government gets involved in making decisions that are not based on health care or efficiency, but pure politics.

Senator DASCHLE. I would only use that as an example of something entirely different. It seemed to me that was as clear an example as we have seen in recent months of veterans trying to protect a health care system that they view solely as their own. And it goes to the point I was making.

The last question. And if you can be very brief. It seems to me that we really have one of two choices here.

You do not want government interfering with the peoples' choices or treatment options, but it seems like our current system and the one that you may be proposing would allow insurance companies and employers to do that very thing.

We are talking about managed care. We are talking about setting certain criteria to be made available for employees and the determination of eligibility for treatment.

Why are employers better suited to provide the criteria for choice and treatment options than government?

Dr. SULLIVAN. Well, first of all, Mr. Daschle, let me simply say this one final quick thing on the VA option. That had built into it the fact that there would always be first priority given to veterans. No veteran would ever be displaced or denied service.

So the idea of protecting the service argument, that really is not valid in so far as what we were instructed not to do.

So we continue to have expenditures that will be unnecessary, access that will be denied to Medicaid and Medicare beneficiaries.

So that simply is a side issue I know, but I want to illustrate what we are talking about with government intrusion where decisions are made for the wrong reasons.

Now, so far as managed care or coordinated care is concerned, I have visited coordinated care facilities. I have talked with doctors. I have talked with patients and others.

There are many examples where care provided is superior, the costs are less, the income of the physicians working in facilities are competitive with others.

That is because coordinated care results in a reduction of inappropriate duplicate care. It has greater preventive services to help control diseases.

So certainly if you look at this in one sense, yes, we are saying that we have to make choices.

We simply have to make more informed choices, better choices for the use of our health care dollars because our current system has a lot of built-in, inappropriate choices, inefficiencies, duplication, and other cost drivers, malpractice, etcetera.

We must address those because we are saying that those expenditures are not for necessary care or needed care.

It does not add anything. But that is what all of us are grappling with when we are trying to bring our costs under control.

We are seeing that coordinated care is one of those strategies that will help us to deliver appropriate care at less cost and get more efficiency in the system.

The CHAIRMAN. Thank you very much, Senator. Senator Rockefeller, do you have some questions?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Secretary Sullivan, you used in your introduction that the President's—let me back up.

To me the test of any genuine reform in health care is two-fold: it has to be universal, not in terms of just access, but coverage.

People in West Virginia have access to go buy Cadillacs, but they do not necessarily have the money. So coverage of health care, universal coverage. And secondly, tough cost containment.

I may be misreading, but I do not think that the President's plan meets that. What is interesting is around here is when you talk, not just to Democrats, but with Republicans, there is a lot of frustration expressed that the Administration which has such a chance to come forward and take leadership on this is not doing it. And I will not speculate on that.

You said all poor families would receive coverage, but your own figures indicate that the tax credit of $3,750 which only applies to people who make $6,700 or less a year.

For a family of four, it runs out at I think almost $10,000. It runs out, no more tax credit at less than $10,000, but the official definition of a family in poverty for a family of four is $13,400.

Now, I want to ask two questions. How can you say number one that your plan approaches universality of coverage if it does not even cover people up to your own definition, which you said, of the rate of poverty?

And secondly, in terms—let just stop right there for the moment.

Dr. SULLIVAN. Yes, Mr. Rockefeller. Let me say there might be some misreading of our proposal. Our proposal does cover a family of four up to an income of $13,400, not $10,000. So it does cover that.

Senator ROCKEFELLER. I thought we had taken this from your testimony. Well, let us take the $14,000. In America, if you make $15,000, if you make $17,000 and you have two kids, you are poor. You may not be defined as poor, but you are poor.

If you have $21,000, you can afford certain things, but you cannot afford to do most basic things.

Now, I want to get at again the question of universality of coverage. You have a tax credit for the poor. You say it is up to $14,000. Second, you have the deductibles.

For a family in West Virginia making $25,000, that is worth about $600. The Chairman said $560. There is no difference between those two.

In the average cost of health insurance in West Virginia, which I grant you is high, it averages around $7,000. The difference between $600 and $7,000 is so enormous that they cannot achieve that at that end.

Where is universality through tax credits or through deductibles?

Dr. SULLIVAN. Senator Rockefeller, let me say this. The President's plan would provide for a basic health care plan. Clearly, there will be richer plans that people want to purchase that would be available to them.

But we believe the obligation of government is to provide basic services. And what the President's plan would do through our financing mechanisms is to benefit some 95 million Americans through either the insurance voucher system or the tax deduction mechanism or the provision for self-employed individuals to have their insurance premiums deductible up to 100 percent rather than the current 25 percent.

So we are trying to provide, with limited financial resources and all of the stringencies I think we all confront, a basic health package.

Two other comments I would like to make. One is that the value of the voucher would provide basic coverage that is already available today in at least half of our States. Plans at the value of the voucher are available.

But with the President's comprehensive plan, that we emphasize should be looked at in a coordinated way because many components in the plan would serve to reinforce the efficiency and the effectiveness of the program, such as health insurance networks, malpractice reform, and other features of that.

So what we are saying is that we can utilize the dollars that we are already spending more effectively and get much more with that, with coordinated care, health insurance networks, etcetera.

Senator ROCKEFELLER. Secretary Sullivan, just answer this question, do you think that universality of coverage and rigorous cost containment is a fair test to put to any quote, comprehensive, end quote, health care plan?

Dr. SULLIVAN. What we are saying is we are giving universal access to basic health insurance. Now, no one has the same size house or anything else here that is provided privately.

What we are saying is the government's obligation should be to provide a basic level of services. We are not saying that the government's responsibility is to provide everyone Cadillac service.

We believe that what we have is a basic health insurance package that would really be a tremendous improvement over what exists now. And we would hope that the perfect does not become the enemy of the good.

I would say that in a perfect world, it would be great to have access to everything. But I think we are all confronted with the fact that we have limited resources, but believe that we have an obligation and can provide basic health coverage for everyone with the President's plan.

The CHAIRMAN. Thank you so much, Senator. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Dr. Sullivan, I have a problem with the importance you place on individual choice. It seems to me—and I am prepared to be contradicted—that freedom of choice is an enemy of cost containment.

You mentioned coordinated care here a good deal today. And sometimes we call it managed care. But in any event, under those programs, there is a limitation to choice. If you want to be under

this program, you have got to go to doctor "X." You've got to go to hospital "A."

And can you explain to me why you keep referring to individual choice and how that fits in?

Dr. SULLIVAN. Well, I would liken it to being at a university. At the university, you have a choice of a number of faculty members from which to take a course.

In a coordinated care program, there is a panel of physicians. So perhaps in the broader sense, you would say there is some restriction of choice because you are restricted to the panel of health professionals in the coordinated care program.

But what we are looking at, Senator Chafee, is the fact that there are a number of choices of health professionals and of health care facilities in coordinated care programs. And these programs are growing.

So if you compare today's number of choices with 5 years ago, you will see that it is infinitely more. Five years from now, it will be even more so because of the growth of these programs.

But what we are saying is that coordinated care does represent a very good option because we have many examples where such programs provide quality care as measured by any index in terms of complication rates, recovery rates, etcetera, as well as cost control.

Senator CHAFEE. Good. Now, could you cite for me the authority for your statement on page 4 that "Canadian doctors according to a recent report, are deeply concerned about their ability to get access for their patients to special care.?"

And then the next comment, "A large majority of doctors in Canada and Germany believe their systems require major overhaul."

As you know, there is a lot of enthusiasm around this place for the Canadian system, because it is held up to us as system that works extremely well. I have my reservations about it.

And usually the reports are that it is favored by both patients and by doctors. So if you have some contrary evidence, I would be interested in seeing it.

And one of the issues that most of us have put a good deal of emphasis on—and I know you have as well—is that of primary and preventative care.

Now that involves a substantial expansion of the community health centers which I understand you support. Am I correct?

Dr. SULLIVAN. That is correct. We propose a $90 million expansion, 15 percent expansion of our budget for community health centers, which would increase the number of sites available to our community health centers to some 1,700. And it would serve almost 7 million people.

And also, Senator Chafee, the source for that citation of the Canadian doctors is a study by Dr. Robert Blenden of the Harvard School of Public Health.

And there was an article citing the study in the Wall Street Journal on June 9, just a few days ago. And this was a study funded by the Robert Wood Johnson Foundation.

Senator CHAFEE. I would be interested in seeing that. That deals with both of them, the German and the Canadian systems.

Dr. SULLIVAN. German and Canadian, yes. It cites that concern of both German and Canadian physicians.

Senator CHAFEE. Okay. I will get that from you later. Thank you very much.

Senator CHAFEE. That is a fast light we got here today, Mr. Chairman.

The CHAIRMAN. Well, what we have is a 3-minute light. And most of you use 4. And we have a lot of witnesses yet to be heard from.

Senator DURENBERGER. Mr. Chairman, I am going to ask just one question. You are in a position, Dr. Sullivan, where you can help us a great deal.

The Chairman and I and others have reported out of this committee already a small-group insurance reform bill. Later we had to take it out, because it was on a tax bill.

I have not yet seen an endorsement of that from the Administration. I think we need to know whether or not the Administration would like to see that bill in some appropriate form passed this year. And I think the President could give it a good kick.

The reality is the small group insurance reform, if we did it, is going to help some people and it is going to help them at the expense of others, which gets me into the ERISA issue.

We cannot deal adequately with reinsurance pools and medical uninsurability unless we get at the issue of ERISA.

We now have a reason to get at the issue of ERISA because a Federal judge in New Jersey has sent panic all over this country to the Governors because that Federal judge has said that the provider tax is an illegitimate form of raising funds to provide access to coverage.

You met with the Governors, or your associates met with the Governors, yesterday, as we all did. It seems to me that while it is a difficult issue to deal with, this is an incredibly important time to get our hands around that ERISA issue and decide what we are going to do about it and how far we are going to go.

Senator Pryor and this committee and Senator Leahy have proposals. I am drafting a proposal. There is no reason why we could not do that within the next month or so and we would cover several problems.

We would cover the problem of reinsurance, small-group insurance reform. We could cover the problems facing the Governors.

Senator Moynihan and I have a Medicaid managed care bill which the Governors desperately need. The Governor of Missouri, who is the chairman of the association, has this problem renewing waivers.

We have a proposal here which I think most of the people on this committee endorse one way or another, which we could get out and get moving if we had your endorsement and some of your strong effort behind doing that.

They want to get rid of the Boren amendment, which this committee passed. I am not sure I know where you stand on it. Then we have the issue of the Medicaid waivers.

They are making some progress at the State level, which the Chairman and others found out on Monday. They need a little help.

I wonder if you could just take each of those issues and make a commitment to the Chairman of this committee that within the next of couple of days that the President, the Administration is going to get off the launching pad this summer with the help of this committee on the kind of things that I have suggested here. At least he could come to us with his proposal that would be backed by the Governors and lay it here and ask us if we would get it moving.

I think the Chairman has just been waiting now for about 5 months for something from the Administration in order to get our bill back up again.

The CHAIRMAN. Well, I really appreciate that, Senator. I thoroughly endorse that request.

And I am looking forward to hearing the Secretary's answer. And if it takes another couple of days, that is fine, too. [Laughter.]

Dr. SULLIVAN. We will be happy to get a response back to you, Senator Durenberger.

As I indicated in my opening statement, we are here to indicate our desire to work with the committee.

Dr. SULLIVAN. We think that there are a number of things that have been introduced by you and by other members of the committee that while we may have differences with some aspects, we think there is much that we certainly can support that we think does have merit.

And I would like to have my colleague, Mr. Moley, comment on some of those issues, including the ERISA issues because he met with the Governors yesterday.

Mr. MOLEY. Senator Durenberger, we, in fact, as you know have endorsed S. 2077, the Moynihan-Durenberger bill which would eliminate the requirement for a Medicaid waiver to use managed care. We think that would be an opportunity to break the gridlock.

And as you know, Congressman Ed Towns is the chairman of the Black Caucus and he testified before a subcommittee of this committee introducing that proposal.

The CHAIRMAN. We are running out of time. Get on to the ERISA. [Laughter.]

Mr. MOLEY. On ERISA, we made a commitment yesterday with the Governors to look at the Leahy-Pryor proposal.

However, we have some significant concerns in respect to the 980 State-mandated benefits and the concern about unintended consequences of allowing those mandated benefits to creep back into those programs and cause additional cost as well as administrative costs to other health care plans. But we have promised to look at it.

The CHAIRMAN. Well, you have a long list yet to try to complete in the next few days for us. We will be looking forward to that.

Senator Rockefeller, you had a comment?

Senator ROCKEFELLER. Mr. Chairman, one point of clarification.

Mr. Secretary, in our dialogue before, it appeared to me that you were trying to say to me that the tax credit for a family of four, let us say, at $14,000, approximately the level of poverty, you were not implying that the tax credit of $3,750 would be full for the family at 100 percent of poverty, were you?

Dr. SULLIVAN. Yes. It would be the full $3,750.

Senator ROCKEFELLER. I think this is very important. My understanding is that it is at a 100 percent only if the family makes $6,700 or less and then it phases out.

At 100 percent of poverty, it goes down by 50 percent and phases out all together at 150 percent of poverty.

Dr. SULLIVAN. It would phase out Senator Rockefeller, at 150 percent of poverty.

Senator ROCKEFELLER. Yes.

Dr. SULLIVAN. This would obviously be phased in over a period of 5 years. But when it is fully phased in for a family of four at 100 percent of the Federal poverty level, which is I think $13,400, $14,000, they would be eligible for the full value of the insurance voucher.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Senator Hatch, I apologize for not having called on you.

Senator HATCH. No, no. That is fine. Thank you, Mr. Chairman.

Mr. Secretary and Moley, I appreciate having you here and I appreciate your leadership in this area.

As I view it, we have had a lot of people talk about how wonderful it would be to have a single-payer system like Canada. But as I view it, there are lots of problems with that Canadian system.

And you have pointed to just a few of them today, some of which I have heard that although their primary care systems may be somewhat roughly equivalent to ours, they are still dealing with 1950's and 1960's built hospitals that are rapidly becoming obsolescent.

Their two-tier system does not compare. They have long cues or lines. Their teenage pregnancy rate is 242 percent above ours according to some statistics.

Their senior factor is about 11 percent of their 26 million are senior citizens; 12.2 percent of our approximately 250 million are senior citizens. You can go on and on.

Could you kind of get your crystal ball out and tell us what is going tot happen over the next 10 years up in Canada and what are going to be the pressures on their system as contrasted to ours?

Dr. SULLIVAN. Well, thank you, Senator Hatch. First of all, let me point out a fact that is often forgotten or ignored when people talk about the Canadian system.

The Canadian system when it was implemented back in the 1960's was tremendously disruptive. Physicians left Canada, came to the United States, went to Australia, went elsewhere.

Senator HATCH. They are still doing that.

Dr. SULLIVAN. There were doctor strikes, as you know. And as I mentioned in my testimony earlier, there are waiting lists for a number of procedures.

In March of 1990, the University of Washington in Seattle signed a contract with British Columbia Province to provide coronary bypass surgery for those who are on the waiting list.

And within a few days, more than 100 individuals had signed up from the waiting list that was there.

So clearly, while I think that Canadians have made a decision as a society that they will make less demands on their health care

system than Americans make, that is the willingness to put up with lines, with waiting lists, etcetera, we are a different country.

Canada is 25 million people. We are 250 million people. We have perhaps over invested in some instances in high technology, but Canada is under invested.

I think many of you have seen the program on 60 Minutes about a year ago that showed the neurosurgeon in Toronto who had a patient with a suspected brain tumor that he had to wait weeks before he could have a MRI imaging technique done that did show a tumor. And then the patient was subsequently operated on.

So clearly, there are problems that exist in that system, but Canada has an advantage. It has a country called the United States on its southern border.

And that serves as a safety valve for those who refuse to wait or get tired of waiting who come across, and who you find in our hospitals are receiving medical care that they have had to wait too long for in Canada.

Senator HATCH. Well, thank you, Mr. Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much Mr. Secretary. We are appreciative of your testimony.

Dr. SULLIVAN. Thank you, Mr. Chairman and members of the committee.

The CHAIRMAN. Next we have a panel that consists of Dr. Ron Anderson, who is president and chief executive officer of Parkland Memorial Hospital, is here on behalf of the National Association of Public Hospitals.

We are very pleased to have you back again, Dr. Anderson.

Then we have Dr. Richard Brown who is a professor of public health at the University of California at Los Angeles.

Dr. David Himmelstein who is the associate professor of medicine, School of Medicine, Harvard University.

Mr. Alan Peres who is the manager of the benefits planning for Ameritech Corp. on behalf of the National Association of Manufacturers.

Dr. Theodore Marmor who is the professor of politics, public policy and management at Yale University.

Mr. Carl Schramm, president of the Health Insurance Association of America. We are pleased to have you back.

Well, we have quite a distinguished panel here. We are looking forward to hearing from you.

Dr. Anderson, why don't you lead off.

STATEMENT OF RON J. ANDERSON, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, PARKLAND MEMORIAL HOSPITAL, DALLAS, TX, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Dr. ANDERSON. Mr. Chairman, we appreciate the opportunity to come before you today.

I would like to thank you particularly for your leadership in Texas, being my Senator, and for the Senators who have visited Parkland to see first hand what public hospitals in this Nation face, but more importantly what public patients in public hospitals in this Nation face.

And Senator Daschle, Senator Bradley, and others of this panel have visited us. And I would encourage you to see your public hospitals in your own jurisdictions.

But patient care is my primary concern. I come to you as a physician as much than anything else today with 20 years experience in the public sector.

I would like to have us try to come to a conclusion or solution with our troubled health care system that would be good for our patients. If it is good for our patients, it will be good for the institutions that serve them. It will be good for this Nation's productivity.

But businesses are suffering under the escalating costs of health care. Employers and employees are having a very difficult time.

And I have had the opportunity recently to be on our Governor's Health Policy Task Force and hear from literally hundreds and thousands of citizens who are in the private sector, who think they are going to join the long lines of Parkland Hospital because of the problems of small insurance reform in other places that this committee is looking at.

Anything tied to a job by definition is limited. If you lose your job, you lose your insurance.

If like one architect in Dallas, you have a small business, you may try anything you can to try to keep that small business so you can buy health insurance when you have leukemia despite the fact that you have $8,000 a month premiums and your whole business is in jeopardy. You have lock-in. And this is a very, very common problem.

Our health care system I believe is on the brink of moral as well as financial bankruptcy. Self-interest and turfism must be put aside to determine what is best for patients to be serviced because we cannot afford the current system.

And in most discussions we have talked about what impact this has on doctors, hospitals, insurers, lawyers, etcetera, we need to put our first priority first. And that will be the patients.

The government cannot afford the current system either. We need fundamental reform, not incremental change, which is like squeezing a balloon. We cut some costs some place and then transfer it down the road.

And really what you will find in the current system is that no one is really accountable, not for costs and not for outcome.

Competition has not lowered costs and, in fact, may have even increased them in many instances. And the fee for service system has not been working to the patient's advantage and to control costs.

The system is really rife with perverse incentives right now that encourage utilization for boutique types of procedures while discouraging preventive health care and primary health care or stopping problems before they get much worse.

In Dallas and the rest of the Nation in 1990, we had a major measles epidemic. There were 68 children who had lost their lives in 26,500 reported cases.

It was found that most of these children actually saw a health care provider, but because immunizations were not covered and for a variety of other reasons, such as the categorical nature of our public health system, these children were not immunized.

We have a system overly dependent upon the medical model, curative medicine, not preventive medicine and public health. These infrastructural issues are deeply underfunded.

While some workers are written out of health insurance, the high cost of premiums has eliminated millions of others. This includes enormous numbers of lower paid public employees and not just the small business.

In Dallas, for example, the independent school district has 22,000 employees. And 4,000 of those employees cannot afford insurance that is there. It is accessible, but it is not affordable.

The Nation's more than 1,500 private insurers each employ cost-cutting measures. And sometimes these are quality related, but many are not.

Many are just second guessing by non-physicians, non-nursing, non-health care professionals. And it does not add anything to the quality or does anything to establish standards of care.

The intrusion by the health care industry is far greater than any intrusion from State or Federal Government.

The cost at Parkland, which is a licensed hospital of 940 beds, is approximately $7 million a year for the paper chase.

This pays for a small army of 300 employees who do nothing more than try to get people eligible for care or to get Parkland reimbursed for the 30 percent of patients with some reimbursement potential.

We do 70 percent charity care. And I must tell you, the safety net is absolutely running over.

We provide care within a health care system noted for staggering waste estimated at one-third of $800 billion. Reducing waste could fund reform. This waste is documented in handouts I have provided to you in the bibliography.

[The prepared statement of Dr. Ron J. Anderson appears in the appendix.]

Dr. ANDERSON. This waste includes ineffective care, unnecessary procedures, fraud, malpractice-related fees, and defensive medicine.

And up to 40 percent of some major medical procedures, such as coronary bypasses, an estimated 250,000 per year, may not need to be done.

Maybe 1 million Caesarean sections may not need to be done. And such waste is occurring at the time when we are talking about rationing of care. And we are talking about disenfranchising even more.

Because the majority of the Nation's poor are African American, Hispanic, and other ethnicities, health care often breaks down along racial lines, adding more to social inequality and inequity, a separate but equal system.

Reducing waste would dramatically increased access to health care. And while I applaud the current Federal efforts to do that, I think only fundamental reform can do that.

Cost-containment efforts should include outcome-oriented emphasis on technology and delivery of services, tort reform, physician guidelines for standards of car—and some of this is being developed in Minnesota presently—regional health systems, negotiated global budgeting, and rate setting.

And I say negotiated because currently, physicians and hospitals get what is set by Medicaid or Medicare. And at least we would have an opportunity to come to the table for that discussion.

But I think we must build in accountability where the cost per recipient per year is known. And perhaps we can cap the increase in health care costs so we do not eat up education, economic opportunity, prevention for crime, and the other infrastructural issues that bring us the health care problems that Parkland that must face.

I will end by saying that there are a number of States who are doing wonderful things, not just other countries.

The State of Hawaii has 6 percent of its overhead toward administrative overhead. This country has 22 percent in the private sector compared to 4 percent in Medicare.

We should learn from Minnesota's single-payer, serve-one-serve-all system. There is a lot we can do if we continue the debate.

And I do not really want to encourage the Canadian system or the German system, but a uniquely American system that says that patients have a right to health care.

And if we ever made that bold step, I believe we would come up with a much more innovative program that would not throw technology to the wind, but we would access technology to see what actually contributes to patient care and come back to the final thing.

The demographics are clear. We cannot throw away our minority populations. We cannot throw away the poor. They are our future productivity. And health care is an important infrastructure, but I do not want to put all the money there.

I know that we are very concerned about education and the other things we have to do. And if you educate and employ people and give them a way out of hopelessness and helplessness and more to lose—as they did not have anything to lose perhaps in the Los Angeles riots—you are going to see a healthier society than all the preventive health care that doctors can bring.

They can do much better with those kinds of interventions. So please do not put it all on health care. Let us deal with the whole infrastructure in this country.

Thank you.

The CHAIRMAN. Well, Dr. Anderson, that is a very thoughtful statement.

I have known Dr. Anderson for awhile. And I have visited many a hospital. I think he is the most dedicated and able administrator that I have had the pleasure in contacting.

In listening to your statement, I understood you to say that the most logical and ethical approach to health care is the single-payer system.

Then I heard you also talk about the necessity of built-in controls. Certainly, we have to have that.

But specifically, you mentioned managed care as a part of that plan. Now, often we think of managed care up here as an alternative to the regulation implied by a single-payer system.

So would you tell me just what you mean by managed care?

Dr. ANDERSON. Senator Bentsen, I am on the board of the Kaiser Health Plan for Texas. And I am really convinced that managed

health care can save money. Sometimes it rewards under-utilization like the current fee-for-service system rewards over-utilization.

But in our own hospital system, we have created a series of clinics, community-oriented primary care clinics, staffed by principally physicians in primary care, many of them are ethnically appropriate for the communities that they work in who not only get a salary and an incentive for quality and productivity, but also a public health bonus for the achievement of goals that we set together as a community oriented primary care.

We think that type of managed health care is real, but we have used the term managed health care so often.

Like a clerk who called me to ask me if we needed to admit a patient who was in the intensive care unit on a ventilator and who had called throughout the hospital every 3 days to see if we could send the patient home. They did not know anything about health care, too.

I am looking at managed health care the way Hawaii does, where you could have indemnity plans, a State plan, but also have the opportunity to explore managed health care like they did.

A lot of their reasons for having lower cost is they have two real payers in Hawaii: one is Kaiser Permanente and one is Blue Cross-Blue Shield.

And I think we can do a lot in the inner cities with managed health care concepts. I think we can do a lot in rural areas, connecting rural and urban systems of care into integrated health care systems that are managed for trauma and burn care, prenatal care, but for primary care as well.

I think probably the term I would rather use would be integrated health care systems. And one of the problems now with community health centers, which I think are very much needed, is that they are often stand alone and not integrated with public hospitals.

They have no access to tertiary care or to hospitalization, even their doctors cannot admit to those hospitals.

I would like to see public hospitals who have been on global budgets from their county commissioners and their States have the opportunity to lead us in that direction, to have an opportunity to create integrated health care system.

We can learn a lot from managed health care I believe.

The CHAIRMAN. I would like to say to the members, I would like to get through the testimony of all before we get back to the questioning. I have taken the liberty of intruding on that rule because I have another meeting. I have to get involved in a 12:00 meeting. Senator Daschle will be chairing.

Senator CHAFEE. Mr. Chairman, I also have to go at noon. Could I just ask Dr. Anderson one quick question?

The CHAIRMAN. All right.

Senator CHAFEE. On page 3 of your testimony, you say that up to 40 percent of common major medical procedures, such as 250,000 coronary by-passes and nearly 1 million Caesarean sections are unnecessary.

How do you know? And what can we do about it? And who is going to call the shot?

I am not being critical. This is very, very revealing information. You have a footnote filling where these figures come from. I am not sure where it is. Footnote 2, Health Progress, November 1991.

Who is going to say which by-pass is unnecessary and which is not?

Dr. ANDERSON. I believe it should be a panel of physicians and others who look at this, not a panel of insurers or clerks or employers who have a vested interest in paying less, but a commission that would take a look at the types of preventive care, health promotion that should be provided as well as standards of care.

In Minnesota, they have explored this. And they are saving anywhere from 10 to 15 percent in actually improving the quality of care using continuous quality improvement, looking at the science, really, and applying epidemiology and public health tools to see what really is necessary.

It's wrong to make more money by doing a Caesarean section on a Medicaid patient just so you get to go home at night and do not have to sit up all night with a mother, doctors do that.

If they are worried about malpractice, they will do that, too, because they want to be sure it is a good baby. And so they are more likely to be able to do everything under sun at more expense and avoid malpractice. So a Caesarean section becomes the option. At Parkland, we do 16 percent——

Senator CHAFEE. But doesn't this tie in with the issue of malpractice? The Caesarean clearly must tie in with the threat of malpractice.

Dr. ANDERSON. Yes. Of 15,000 babies born at Parkland each year, we do 16 percent Caesareans. In the private sector, studies show they do 28 percent. Up to 35 percent of Caesarean sections are done with no difference in outcome.

The key issue is to be outcome-driven to know what cost per recipient per year is and to know what the outcome is and have that be public knowledge.

Senator CHAFEE. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Brown, if you would proceed.

STATEMENT OF E. RICHARD BROWN, PH.D., PROFESSOR OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA, LOS ANGELES

Dr. BROWN. Thank you, Mr. Chairman.

I think that the issues that we need to address and come to agreement on much less involve a particular model that any of us might be advocates of than a set of reform goals—goals that we believe health care reform must achieve in order to be considered acceptable to us whether we favor a pay or play model or a Canadian style health insurance or single-payer model, such as Senator Wellstone's, or a universal tax-funded program, such as Senator Daschle's or Senator Kerrey's.

I think we desperately need to achieve five fundamental goals in reform. The first one is to cover the entire population for comprehensive health benefits. That is an obvious one. And I think there is fairly universal agreement on all five of these.

The second one would be to create a system that provides equitable access to quality health services so that people who are in-

sured, if there are different plans or programs, all have equal access to the same kind of care.

Third, to make the financing systems for health services more equitable than it is. It is highly regressive now, where lower income people pay far higher shares of their incomes for health insurance premiums and out-of-pocket medical costs than upper income people do.

Fourth, to control health care costs effectively and fairly, not putting the burden where it is least able to be born.

And fifth, to obtain more value for the resources we now devote to health care.

I believe there are two fundamental reforms that we must, that Congress must enact to accomplish all five of these goals.

First, I think we need to replace the private payment of premiums for health insurance with a tax-funded system, something on the order of Medicare, but on a universal basis.

I think that that has enormous benefits. One of those benefits is that it will untie health insurance coverage from employment. And that in itself has benefits.

It has benefits of instantly creating a universal system in which everybody has a stake in protecting that financing system.

It frees employers from the administrative burden of negotiating or purchasing health benefits for their employees and dependents, letting them do what they do best, which is to run their businesses, not to negotiate health benefits.

It also eliminates disruptions in coverage and doctors and hospitals when people have changes in their lives or changes in employment.

And finally, it can, give all people far more choice than they have today or than they would have under competing proposals for the kind of health plan or the particular physician or hospital that they would like to get their care from.

Tax funding is also fairer because tax contributions of workers and their families and the self employed are at least proportional to their earnings. They can be made even more progressive through the tax structure.

And tax contributions of employers under such a system are also proportional to the wages that they pay, which is also fairer to employers and especially to small and economically marginal employers.

The second reform I think we need to enact is to control the cost of care by reforming provider payment. We have had a great deal of emphasis in this country in cost containment, cost control on the side of controlling demand, controlling demand by increasing cost sharing for patients.

And I submit that this is both unfair and ineffective. First of all, it is providers, doctors in particular, who generate most, in fact, the overwhelming proportion of health care expenditures in this country.

Patients are the people for whom they recommend and order this care, but it is doctors who have the say and it is doctors who are in the best position to be able to control those costs.

Universal national health insurance systems recognize this greater control by doctors in their approaches to controlling costs.

Under the Canadian model of national health insurance, the government is responsible for paying doctors and hospitals directly.

Copayments for physician and hospital care are prohibited in Canada. Most Canadian provinces control their health spending by the use of fee schedules and expenditure targets, very much like the volume performance standards that Congress recently adopted for the Medicare program.

Under the model represented by Senator Kerrey's Health USA bill and similar proposals, this adapts some of the best features of not only the Canadian and European methods of paying for health services, but it does so on a particularly American foundation, the foundation being the widespread existence and choice among health plans.

Under Senator Kerrey's proposal, for example, which is not a Canadian-model system, each family or individual may enroll in the health plan of their choice with the State program paying a capitation payment to that plan for each person enrolled.

That plan is then responsible for managing the cost of the care for that family. Hospitals would be paid for each admission based on a negotiated annual budget target. Professional providers would be paid under a set fee schedule with an overall expenditure target.

This system emphasizes cost containment methods that influence provider behavior. And I believe that this is a fairer and more effective way to go about this. It uses financial incentives to control cost rather than having micro-management of health services.

The only alternative is to increase the use of utilization controls and patient cost sharing. Utilization controls intrude into clinical decisionmaking by physicians.

And increased patient cost sharing deprives the less affluent of needed care. Senator Kerrey's proposal minimizes the need for these methods.

I believe that these two fundamental reforms, that is shifting from private payment for health insurance premiums to a tax-funded system and restructuring the way we pay providers, can accomplish most of what all of us would like to see in a health care system reform.

It creates a solid foundation from which our system can further develop. And I believe that the single-payer national health insurance proposals, both the Canadian model and the proposals like Senator Kerrey's, are a standard against which other proposals for health care financing may be judged.

Thank you very much.

[The prepared statement of Dr. E. Richard Brown appears in the appendix.]

The CHAIRMAN. Dr. Himmelstein.

STATEMENT OF DAVID U. HIMMELSTEIN, M.D., ASSOCIATE PROFESSOR OF MEDICINE, SCHOOL OF MEDICINE, HARVARD UNIVERSITY, CAMBRIDGE, MA

Dr. HIMMELSTEIN. Thank you, Mr. Chairman and members of the committee.

I am a practicing physician as well as an academic. And I represent here today an organization, Physicians for a National

Health Program, of 5,000 American doctors, advocating a Canadian-style, single-payer national health program.

I might note that we are the fastest growing medical organization in the United States today.

I need not review with you all of the details of the crisis in our health care system. We I think have quite broad agreement on that crisis. I would point out a few of the problems that receive less attention.

One is that despite 70 years of reliance on private health insurance, we are, in fact, moving away from the solution through that private health insurance mechanism, not towards it.

We have 10 million fewer people privately insured today than was the case 10 years ago. And during that time, private insurance premium revenues have risen more rapidly than at any time in past history.

Moreover, many of those with private coverage have such inadequate coverage that they are unable to afford needed care despite their insurance.

For instance, 5 million young women with insurance have coverage that excludes maternity benefits. And very few Americans have adequate long-term care coverage.

Hence, we have a problem not only of uninsurance, but of under insurance. And any reform must deal with that problem as well.

Third, much of health spending, as Dr. Anderson has said, is wasted on unnecessary and even harmful care and facilities. And our pro-competition policies of the past decade have encouraged medical arms race with a proliferation of unnecessary facilities.

For instance, while the American College of Surgeons tells us that hospitals that do a small number of complex cardiac procedures do not do enough to be good at it. A third of the hospitals in California today doing open heart surgery are doing dangerously low volumes that increase both the cost and the mortality rates.

Fourth, a well-funded misinformation campaign has sought to misportray the Canadian health care system and its problems. Canadians receive substantially more care per capita than Americans do, including many kinds of high-technology care. I have included in my testimony a chart comparing the number of transplants per capita in our two nations, showing that, in fact, Canadians receive substantially more of a variety of these high-technology procedures than we do contrary to the widespread impression.

[The prepared statement of Dr. David U. Himmelstein appears in the appendix.]

Dr. HIMMELSTEIN. It is notable that Canadians spend almost $1,000 per person less each year for health care than we do and yet receive on average more care than we do. For any given level of health spending, the Canadian approach yields more care and less paper work than ours.

What we would advocate for this country is not a Canadian system, but Canada Deluxe, that Canadian system inflated with the $1,000 more per capita that we now spend.

The final point that I want to emphasize, and that I will dwell on for a moment, is that our private insurance system, and a mixed public-private program, require massive bureaucracy that can only

be substantially and effectively reduced under a single-payer system.

All of the alternatives achieve only a fraction of the potential administrative savings of the true single-payer approach.

To review with you some of the data, on administrative costs I am afraid my work has kicked off controversy in this area, our Nation spends, according to the GAO, about 10 percent more of total health costs on health administration than we would under a Canadian-styled program, saving potentially $80 billion this year. We think that is a conservative estimate.

We will spend about 1 percent of gross national product this year in the United States on health insurance companies' overhead, as compared to one-tenth of that amount in Canada.

And again, a chart that is included in my testimony displays that the overhead in other multiple-payer systems, notably Germany and the Netherlands, is quite comparable to ours.

In fact, the Director of Health Statistics for the Organization of Economic Cooperation and Development has commented that there is a uniform difference in administrative costs between single-payer and all other systems, with only single-payer systems achieving significant administrative economies.

Managed care programs unfortunately offer essentially nothing in administrative savings as compared to the current private insurance bureaucracy. And again, I have included charts in my testimony that refer to that.

An example that I think is particularly striking is that of the Prudential managed care program in New Jersey, enrolling 110,000 individuals. And to supervise the care, 18 nurse reviewers, 5 physicians, 8 provider recruiters, 15 sales representatives, 27 service representatives, and 100 clerks perform only administrative functions on behalf of the insurer.

Blue Cross-Blue Shield in Massachusetts to cover 2.5 million residents of our State, employs 6,682 personnel, more than are employed by the entire Canadian national health insurance program to cover 26 million Canadians.

And it is not just the insurance overhead, but the costs that are inflicted on providers. The average physician in this country spending roughly 10 percent of gross income for their insurance paper work. And my practice is no exception to that. And hospitals face similar complexities.

Only through a single-payer approach can one get these administrative savings and devote this money to providing the care that is currently not being delivered.

All other approaches require either more funding or less care. And the more one compromises on a true single-payer system, the more one gives up either on cost containment or on access to care.

Thank you very much.

The CHAIRMAN. Thank you. That is quite interesting.

Mr. Alan Peres, if you would proceed, please.

I apologize now, but I do have to leave. Senator Daschle will be chairing.

STATEMENT OF ALAN PERES, MANAGER, BENEFITS PLANNING, AMERITECH CORP., CHICAGO, IL, ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. PERES. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am Alan Peres, manager, Benefits Planning at Ameritech, a telecommunications and information services company headquartered in Chicago.

I am pleased to appear here today on behalf of the National Association of Manufacturers.

I am particularly pleased to be here today as I have lived for 13 years in Canada, 7 of which I spent as a hospital administrator in Montreal.

We thank you, Mr. Chairman, for holding this hearing on health care reform and for introducing Senate bill 1872.

We consider that bill an important first step while we continue to debate more comprehensive reform solutions.

Several months ago, Ted Koppel hosted a show on the health care crisis. A well-known Chicago physician, a fierce advocate of single-payer systems, talked about his recent 1-day trip to Toronto to see first hand the Canadian system.

He said that system would work here because Canadians are just like Americans. Well, let me tell you that Canadians are not Americans that are born with hockey skates on their feet and say, "oot and aboot."

There are very big differences. And we need to understand those differences as we look internationally.

A couple of years ago, one of the American television networks had a detective show called "Night Heat". Suspects were arrested and charged without ever being "Mirandized."

Well, that is because the show is Canadian and there is no equivalent to the Miranda ruling in Canada, but I doubt that very few Americans even noticed the difference.

While Americans have been inundated with information on the Canadian health care system, we really do not understand the legislative and cultural underpinnings that make that system work.

When looking to Canada, you must first look to its parliamentary system which combines legislative and administrative functions under the responsibility of a single cabinet minister. That person is the person to whom you point at if something goes wrong or something goes right.

There is no single Canadian way of doing things. Health care is a provisional jurisdiction. There are 10 provinces and two territories, each with its own health care system.

Unfortunately, many commentators, even Canadians, talk about the Ontario provincial system as if it applied to all of Canada.

It does not. One need only look to Quebec, the province to its immediate east to see very real differences.

There is no American parallel to the Canadian government structures. We do not have clear jurisdictional provisions. We have separation of powers.

Responsibility and accountability are defuse, sometimes to some observers they appear to be nonexistent.

Canadian education from elementary school to post-graduate studies is funded and regulated solely by the provinces.

As a result, provincial governments control medical school budgets. They control medical school slots, the number of residency slots, and the mix of specialties to be produced.

In addition to the production of doctors, the government can influence the number of new physicians allowed to bill medical plans through licensing and control of billing numbers and where doctors practice through reimbursement differentials.

In at least one, there are controls on the size and specialty mix of hospital medical staffs. Controlling physician supply, as some evidence has shown, will significantly affect, in and of itself, health care expenditures regardless of the method of payment.

Unlike the clear provincial responsibility in Canada, American proposals for State-based program administration may be problematic. Unlike Canada, we have many urban areas crossing State borders. In Canada, I can think of only one.

We frequently have bi-State if not tri-State urban areas. It is not uncommon for Americans to cross State boundaries to work, shop, and seek medical care.

The following can illustrate the resulting dilemmas. Should the New Jersey government, for example, be allowed to encourage people to use New York or Pennsylvania providers as a means to restrict its investments and its expenditures?

Will Massachusetts physicians and hospitals have to accept New Hampshire reimbursement as payment in full?

Will New Yorkers be allowed to go across the country to facilities such as the Mayo Clinic or M.D. Anderson Cancer Center?

Will patients even be allowed to cross borders? Who will make those decisions?

It is easy to talk about portability. But will it be allowed to occur?

Canadians are supposed to have portability under Federal law. However, a Quebec resident receiving care in any other province for any other reason is reimbursed at Quebec rates which are 30 to 40 percent below other provinces. The beneficiary is responsible for the difference.

We also cannot ignore differences in patient expectations. In May 1989, the Chicago Tribune told of a Japanese law suit. A deceased patient's family sued her physician, who told her she had gallstones. The actual diagnosis was gall bladder and liver cancer.

The suit contended that had the patient known of the cancer, she would have agreed to surgery and would likely still be alive.

The court ruled that the doctor has no obligation to fully disclose information which he or she feels may be harmful to the patient.

The article said that in Japan cancer is considered to be almost always fatal. Doctors do not tell their patients of the presence of cancer to maintain the patient's will to live.

Americans, on the other hand, have very high expectations fed by a constant stream of news about the latest trends in medical care. Americans search until they find the "magic bullet."

Our physicians use the latest technology both to meet their patients' expectations and to ward off liability concerns if they do not. This, too, contributes to costs which are so much higher than those in other countries.

Essentially, the question we are facing is not which proposal is right. It is what kind of health care do we want.

Do we want, for example, insurance for catastrophic and unpredictable events? Or are we looking for prepaid benefits, including preventive services?

And how much government involvement do Americans want in the health care they receive?

The polls and focus groups do not show a clear understanding of the issues by the people, let alone a consensus on solutions.

To quote a man from Flint, MI, recently interviewed about his views on national health insurance: Yes, I would like national health insurance, but I do not want the government involved.

Mr. Chairman, thank you for the opportunity to testify today.

I would ask that my written remarks be entered into the record. I would be pleased to answer any questions that you or the committee may have.

Senator DASCHLE. Without objection. Your entire statement will be made a part of the record, Mr. Peres. Thank you for your comments.

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

Senator DASCHLE. Dr. Marmor.

STATEMENT OF THEODORE R. MARMOR, PH.D., PROFESSOR OF POLITICS, PUBLIC POLICY AND MANAGEMENT, YALE UNIVERSITY, NEW HAVEN, CT

Dr. MARMOR. Thank you, Mr. Chairman.

I am here today representing officially no one I can think. As I have listened today, I have thought that perhaps I represent those who earn their income trying to make true statements about comparative health systems. And I have a written statement which I assume you will put in the record.

Senator DASCHLE. Without objection. It will be made a part of the record.

[The prepared statement of Dr. Theodore R. Marmor appears in the appendix.]

Dr. MARMOR. Because this is late in the morning, let me try to put more emphasis on my overall conclusions.

I thought the Chairman's introduction to this hearing was extraordinarily clear. When he said that Americans want substantial and fundamental reform, I think he is right.

And when he went on to say that doing so in the Congress is difficult, he was surely right. And I will spend some of my time trying to illustrate why that is so.

It is we who have a political system that is organized in such a way that there are lots of veto points. We got a dense, pressure group jungle that makes it very difficult to get agreement.

And finally, we have a situation ideologically where something like universal health insurance brings out both fundamental value differences and fundamentally different views about how the medical world works.

So I am not going to review further any of that. What I want to do is two things, one briefly and one slightly longer.

The brief item is just to say that I do not recognize much of what is said about Canada's performance in hearings like this. And I think there are two intellectual errors that get made.

First, people like myself who think that Canadian national health insurance has something to tell us are pushed into the silly position of saying that there is no strains and problem up North. Anybody who would think that about Canada would be a fool.

So it seems, Canada has to be problem free to be meritorious for review. If we portray it as problem free, we cannot be truthful. So that is a very bad starting point.

The second erroneous intellectual move is this: even if it is pretty good up there in Canada, it is different down here and we cannot learn from Canadians because we are not them and they are not us. This is intellectual know-nothingism.

I would just like to summarize a lot of work I have done by saying this: if the United States cannot learn something from the experience of Canada, it cannot learn from any country.

We are not identical. Canadian Medicare is not problem free. But the United States and Canada are sufficiently similar that if one were thinking about places to look, you would look there.

But let me turn to the real point of my testimony this morning which is an analytical one more than a promotion of a single-payer plan.

I have been struck that most of the discussion of something called single-payer has no theory about why a single-payer pays less.

If you review the OECD countries' experience over the last two decades, you will notice that the United States has had the worst health cost experience. All those other countries at one point or another in the 1970's and 1980's leveled off the proportions of their income expended on medical care.

Some OECD countries have straightforwardly single-source medical financing; some do not. But all of them have a much more substantial role of government in determining who gets what budget for medical care and how much that budget is going to be.

But having said that, there is no elaborated, well understood reason why it is so.

Why should it be so? After all, we have a single-payer system for defense in the United States. And that payer was not notable in the 1980's for cost control. It does not follow, in other words, as day follows night, that a single-payer form alone does anything in particular.

Well, let me briefly suggest and leave open for questions what I think is important about the form. First, the term "single-payer" itself is a terribly inadequate descriptor.

What we are talking about are health systems that have universal coverage, a politically accountable body, and a budget. Those things in combination seem important, not one alone.

Second, it looks to me as if we confuse too much where the money comes from than from the pressures on the people spending the money. The money can come from lots of different sources. What is important is the organization of restraining pressures.

After all, Canada, as one of the speakers said, has 10 different provincial plans. The Federal Government provides some of the

money and not many of the detailed rules—but a lot of the fundamental ones—and the rest of the provincial money is raised in lots of different ways.

But there is a single source of payment in every Canadian province, just the way there is a single source in every Swedish country, just the way there is a single source all over Britain.

Now, why should a single source be restrained? Well, my only suggestion to you is this: if you have a universal plan so that everybody's stakes are affected by what the single payer does, and if you have continuous demands for more, as you do everywhere in the Western industrial world, what the single responsible, accountable agency must do is balance increased cost against increased claims for more care and pay.

That is to say, single payers must set the pressure for more spending against the pressure for less spending.

Now, who is enforcing that restraint? Surely not physicians and hospitals and patients; they are not the forces pressing for cost restraint.

What I would suggest to you is that the best organized source of anti-inflation control in single-payer systems are the other claimants on the public budget who lose when inflation in medical care rises more rapidly than national income.

In other words, if you are thinking about why in Canadian provinces there are tremendous pressures to restrain expenditures, it is the Department of Education or the Department of Transportation and all the other government departments that know that if the rate of medical inflation is 1.5 times the CPI. There is going to be less money in their budgets.

And the provinces are counter-balanced, on the other side, by tremendous constraints on tax increases.

As a last point, I would vote that the other alternative, of course, when there is cost pressure, is to cut health benefits. And that is where the universality principle is important.

Because if you have universality, with everybody's stakes involved, you are not pressured in the direction of squeezing out benefits as much as you are pushed in the direction of squeezing on the payment levels and taking into the account whether the capital supply is too lush.

And I just cannot miss this one point. The picture of the single-payer is not limited to Canada—I use Canada as only an illustration of a single-payer—I am not restricted to it. There are Australia, Britain, Sweden and others.

But in closing, I must note that if the United States were to drop off the face of the earth tomorrow, Canada would be the most expensive medical care system in the world.

The imagery of Canada, as this starved, third-world Nation, unable to supply medical care to its citizenry, so detached from the broader health standards and expectations, is one that Canadians consider they consider it intellectual acid rain. [Laughter.]

And they are anxious to get an anti-pollution tax on this acid rain.

Thank you very much.

Senator DASCHLE. Mr. Schramm.

STATEMENT OF CARL J. SCHRAMM, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. SCHRAMM. Thank you, Mr. Chairman. And thank you for inviting the voice, as it were today, of the private insurance industry.

I begin by trying to shed a little light from a different perspective on some of what this panel has talked about in terms of international comparisons.

Last month, for the fifth time in my 5 years in this particular assignment, I was in London at a seminar at Lloyds.

Lloyds as you may appreciate still provides the great majority of the world's reinsurance for health insurance, including a very substantial part of reinsurance for American private insurance both Blue-Cross and commercial insurance companies.

Among the 24 syndicates that provide this coverage and protection to the world's insurance market, are some of the best experts as you might imagine in comparative judgments of insurance systems and health care systems.

Again, I was struck as the representative for the American industry at the seminars by the curiosity always put to me about what is happening in the United States in terms of our public debate around insurance.

And always the precedent in the question is, "With the rest of the world moving to private insurance systems, how is it that the United States has a full-scaled debate about single, centralized government replacement of private insurance?"

And indeed the speculation goes further in London to the direction of suggesting that within 3 or 4 years it is a virtual certainty, private insurance will once again be observed in Canada.

I will join that observation with a second observation and that is HIAA is the representative in the American insurance industry, now almost in the world.

Last month, as is the increasing frequency in our offices, it posted three international delegations. Again, the question they put to us is, "How does private insurance work?"

These delegations included high-level officials, including the Deputy Health Secretary of Russia.

As public policy debate appears to be emerging in the eastern bloc and other parts of western Europe, the question continually put to us and our companies is "How is it that we can't, in fact, establish a system like yours?"

Perhaps related to that is an observation in the last 10 years, 12 percent of the population in England has, in fact, been enrolled in comprehensive private insurance systems.

The third observation I made relates to the comparisons we have talked about. And it is important to observe that many countries do much better than ours from a statistical basis.

I think you have had sophisticated comments from several panelists today, including Professor Marmor, regarding the dangers of drawing these comparisons.

It is instructive I would suggest to say that Canada is a different place and yet is very similar to us. But from a perspective of what the differences are, we should appreciate that in 1970 and in 1960 before the emergence of centralized government-financed payment,

Canadians spent roughly two-thirds of the GNP or GDP share of Americans on health care.

They are exactly in that same position now. And their rate of inflation, in fact, exceeds ours in terms of the annual increase in costs.

I would suggest that that observation leads us to understand that there are important things about Canada. There are things of principle.

Canada, in fact, ensures that every Canadian has the financial means to get the care, that is, in fact, critical.

And Canada has a debate about cost. It is a centralized and public debate. And that is a critical advantage over ours.

But after that it seems to me we struggle with endemic problems that are typical only in the United States. They are foreshadowed in other countries to be sure, but their magnitude is only American.

There are supply-side problems. And you are all familiar with the over supply of physicians and the twist in 25 years from a population of physicians that was largely primary care physicians to one that is now almost 75 characterized as specialty and sub-specialty care.

That is part of our public debate that I hear very little of from the halls of Congress.

We talk about obliquely influencing this through the reform of markets and rules, managed care, etcetera, but, in fact, that is reality that exists as a consequence of direct public policy emerging from this body, the Congress.

Likewise, on the demand side, we see enormous over production of surgery which is, in fact, a function of our supply side problems with little discussion of directly influencing that.

We have a tort system that is endemic to this society. And others have commented on it. And we have rules that the State influence the way we behave in the insurance market both public and private.

I would suggest that the answers lie in a route that we have talked about that is a pedestrian route and is a hard route. It involves reforming Medicaid. It involves reforming ERISA.

It involves changed tax treatment which this committee is contemplating in a small group of reform offered by the Chairman and Senator Durenberger and others.

It involves small group reform. Again, a leading area of interest in action by this committee. It involves the emergence of managed care.

I close just by making one observation on the small group reform area, if I might. At the dawn of this year, 1992, two States had enacted small group reform proposals.

I am pleased to suggest that largely at the hands of the private insurance industry working with a wide number of States, we now have enacted 14 State bills that cover the guaranteed issue, rate regulation in the small market, a mandate with coverage of whole groups, and establish elimination of underwriting in the small group market. And in a number of these, establish a private reinsurance mechanism.

So the job in terms of small group is moving. We appreciate the interest and continued pressure from the Congress and this committee in particular. We are attempting to establish an important precedent at the State level in this area.

Thank you.

[The prepared statement of Mr. Carl J. Schramm appears in the appendix.]

Senator DASCHLE. Thank you, Mr. Schramm.

I want to thank each one of our panelists.

In my view, this is one of the best panels we have had on health care in all the hearings I have attended here in the Finance Committee because of the tremendous representation demonstrated here and articulated in the views of various philosophical approaches to health care reform.

And I must say, we all have been the beneficiaries of some excellent testimony.

Senator DURENBERGER.

Senator DURENBERGER. Mr. Chairman, thank you.

I agree this is a really good panel. I do not know if I flatter them too much to say they are the best or something like that, but it is a good panel. [Laughter.]

The unfortunate thing is we always get to the panels about 12:00 or 12:30. We keep saying the same thing at every one of these hearings. Maybe one of these days it will change.

I really regret that I am one-half hour into two different commitments that I have made. I wish we could just stay here for an hour and debate this.

I hope that with those of you particularly who believe that a single-payer Canadian system is a good one, I would like to personally continue a dialogue, because that has not been my impression.

But I am impressed in the way in which the arguments have been laid out today.

My problem is this as a legislator. I heard Ted Marmor say something about why do we not look at Canada and so forth. I wrote down here that there is a distraction in trying to learn from the experience of a foreign country which keeps us from working to learn from the experience of the United States.

That bothers me a great deal. I believe everything you said about the politics here, particularly the politics of how most of us for 20 years have been destroying the one institution that really could help us get this job done in the name of our own political careers. The media is brought into the same sort of thing.

But I worry about spending too much time going to other countries, looking at their systems because it distracts us from trying to find out what it is that really works in America.

The second point is that when I was growing up, my health care was a relationship between my family and Dr. Baumgartner who lived about 10 miles down the road. He came with his black bag and that was it.

The worst thing that ever happened to the system was when somebody introduced my father to health insurance. [Laughter.]

Health insurance is a wonderful institution. I respect everybody who is in it.

The problem is from that point on, both of us could send our bills, both me and my dad, and Baum could send his bills to the insurance company. We developed a notion that neither of us was responsible for the cost consequences of our actions.

We got wonderful things out of it, the greatest medicine in the world, great doctors, all that sort of thing, but the downside is we are breaking the bank and making health inaccessible for a lot of people.

My problem with what I hear from supporters of the Canadian system is that you are suggesting that we maintain this basic cost insensitivity by saying, "Somebody else ought to pay all of these bills," and by saying, as somebody said here this morning, that "The tax of a premium is worse than the tax of a tax."

Well, maybe you can total it up. And you can say that the total amount gets worse.

But from the standpoint of me as an individual consumer or me as doctor or hospital administrator taking some greater responsibility for what I do, how I behave, how I make choices, it seems to me there is an inconsistency in saying we are not going to expose any of us to the cost consequences of our actions.

My third point is just to quote from my statement in the record today about cost containment. Most of these plans depend on to some degree on a national health budget with the provision that providers be paid on a fee-for-service basis and hospitals and other institutions be paid on a fixed budget.

These kinds of methods are very similar to the way providers are paid in Canada and much like the system we have in Part B in Medicare.

The problem for me having sat here for 14 years is that both Canada and Medicare Part B have failed to contain spending.

Between 1980 and 1990, inflation adjusted cost per person rose just as fast in Canada as in the United States, 52 percent there and 53 percent here. And under the Medicare program, payments to physicians in this country rose 135 percent even after adjustment for inflation.

We can debate what goes into that. All I am saying is that cost containment efforts that rely on fee schedules are doomed to fail in my view.

The best way to control cost—and I am just quoting myself——[Laughter.]

Senator DURENBERGER [continuing]. It is not something that I hear very often which is to improve the productivity of the health care system. I am basically talking about putting a value on health to begin, rather than the fetish we have for medical miracles, and then changing the practice of medicine so that we get more health for our health care dollars.

You heard me earlier talk about who knows whether Mayo was the best in the country. A bunch of doctors said it is, but I do not know whether it is the best.

But if it is the best, why in the world don't we send everybody to the Mayo Clinic? Why are we spreading them out over all these hospitals that you talked about with questionable care?

And that in part is changing consumer behavior and, in large part, changing provider behavior.

I cannot see how government is going to get that job done. I can see a role for my State of Minnesota, because of the nature of that place, trying to put the spotlight on innovative provider changes.

But when I look at the United States, turning over to 50 governments or one government productivity, I just say to myself, "Government productivity is an oxymoron"—unless you can tell me it is not.

Does anybody want to respond to that? Speak up anyone.

Dr. Brown. I think, Senator, that pointing to the example of Medicare Part B is an interesting case because, in fact, what we saw in Medicare in the 1980's was the implementation of effective cost controls on Part A of Medicare, in-patient hospital care only.

And the response of doctors and hospitals was to push outside the hospital everything that they could because there were not effective cost controls on Part B. And there still are not effective cost controls on Part B.

There is the beginning of a system and a structure for paying physicians, which it might, if it is implemented effectively and vigorously, lead to cost controls through the volume performance standard, imposing some lid potentially together with fee controls.

In any kind of system, the total costs of that system are going to be generated by the price of the unit of service times the volume of services provided.

And if you control only the price just through a fee schedule, that will be an ineffective way to control spending because we have seen in this country and in Canada and in European countries that physicians will increase the volume of services they provide in response to a freeze on fees.

A recent study by the GAO, which did compare the effectiveness of expenditure and fee controls in France and Germany, looking at changes that were implemented in those countries in the last decade or so, found that the simple imposition of a fee schedule essentially accomplished nothing in cost control.

But the implementation of a fee schedule with expenditure targets or budget lids did do so. And only when the government or the paying agency, which might be private in an all payer-system—which I think is an excellent solution to the cost problems—has budgetary control over the system.

Senator DURENBERGER. Dr. Anderson.

Dr. ANDERSON. Senator, I agree with you. We sometimes get derailed when we are talking about one system in particular.

The thing that really I wanted to come here today for is to not let us get derailed on trying to simply define an insurance program.

I agree with you about preventive health care and health promotion and creating that infrastructure that needs to be there in rural areas.

We have had 133 hospitals close in rural Texas. In the inner cities, except for the public health clinic systems, they are not providers.

If you had national health insurance tomorrow and you wanted a system of choice, you would not have one. You would add to the burden in a two-tiered system at the public hospital.

We would like to see us thinking about the infrastructure and the productivity, not just to the health system, but the productivity of our communities.

And so many times, we look at Dallas. It would be a non-majority population in the year 2010.

And the business people are way ahead of us in many ways, looking ahead at the demographics, not predictions, but projections. And we hope they will look at us as they look at education and business opportunities.

And other things have to be done, but I do not think the answer is solely within the health system. And I agree with what you are saying.

We need to look more broadly at the other infrastructural issues, not just Canada or something else or not just medicine in the medicine model, but health and community models.

And ultimately, we want to fund what we say we want. We fund many anti-family programs. The connection of welfare and health care just happened to be where Medicaid was.

Maybe federalization of Medicaid is one step closer to defining what everybody should be provided.

I come from a State that is 49th from the lowest. And poor people in Texas do not seem to be worth as much as poor people in Minnesota. I think they are. I think under the Constitution they should be. And it is unfair.

And I actually was told by someone from North Dakota. "How do you handle poor people in Fargo?" And he said, "Well, there is a bridge over to Mooehead."

Senator DURENBERGER. Right. [Laughter.]

Dr. ANDERSON. And so there is still a war between the States. And it is all southern and northern.

Dr. MARMOR. I can see, Senator, that you are ready to leave. Maybe we can just leave it for another time and carry on this debate.

My only two points were that your comment about looking at foreign systems as a distraction really interested me.

I think there is something powerfully important about that. And yet you are caught in my view in a dilemma.

If we do not like our experience over the last 20 years, we can either look to theoretical models or we look to other peoples' experiences as we try to fashion our adaptation.

So simultaneously, it is a source of some insight. And it is a source of exactly the sort of distraction I find myself victimized by answering mythical claims about a place that I actually know reasonably well.

I think we need to ration the commentary on Canada to only get sensible things said. [Laughter.]

Dr. MARMOR. Secondly, I did want to bring up this point. It is fascinating to me that what you are suggesting is in some ways less modest than the single-payer reforms are.

You are hoping to get productivity inducements in a range that is beyond what the system of paying for health care can deliver.

My sense is this, to the extent single-payer plans work—and we can dispute some of your numbers on that, but just forgive me for

the moment. Let us stipulate that they have done better on cost control.

To the extent that they have done better, they have not done so by paying only for right things. They have done it by putting a budgetary ring around the total system and enforcing players within it to bargain and negotiate.

That is contentious. It is continuing. It never gets fully settled. It does not bar efficiency gains, but it does not entail them either.

And I think we have intellectual competition between those who believe that managed competition, at a decentralized level without anybody choosing the outcome, will prove to be okay as opposed to what I would call monopsonistic competition where competitors for those budgets are providing the same restraints on the budget side.

Senator DURENBERGER. That is very good. Yes. I agree with that.

Dr. MARMOR. And if we talk about that, I think we would make some progress.

Senator DURENBERGER. That is what is going on right now.

Dr. HIMMELSTEIN. Just a couple of things. I would agree with what Ted Marmor says about the distraction and with much of what you say.

My concern is that if we leave ourselves only with theoretical models of what might work, if we pursue what Winston Churchill remarked about as, "You can always rely on Americans to do the right thing after they have exhausted all of the other possibilities." It does not seem to me that is a constructive way to make health policy. And it is what we have been doing.

We have gone through pro-competition models. We have gone through a variety of public-private mixes.

Carl Schramm asked us to expand Medicaid, which we did in 1990. And we added 3 million people to the Medicaid roles, but we had 1 million more uninsured despite that addition.

So I fear that kind of incremental policy change based on theories that have not been actually looked at in practice.

The question of who controls cost, one of the things that I am acutely aware of as a physician is the extent to which the physicians have enormous discretion about the cost of care and the practice of medicine.

And the attempt to scrutinize that on a case by case basis and hire more bureaucrats to tell us what to do is really a losing exercise.

My colleagues and I are far more creative than the bureaucrats who try to supervise us are likely to be.

On the other hand, if you tell us what resources are available to us and give us a reasonable amount of resources, we adjust our practices very effectively to stay within that resource.

And the best person to not do an unnecessary operation is the surgeon. They would much rather operate on someone who needs the surgery than on someone who does not.

Now if you give them enough latitude so that they can do both, they may do both. But make them make a choice, and they will operate only on the person who needs it.

We know concretely that works. When the Massachusetts General Hospital's ICU beds were partially closed due to a nursing

shortage, there was a sharp decrease in the number of intensive care days.

And it was carried out in a completely collegial and informal manner with no bureaucratic intervention, no harm to patients. The doctors judged who needed those resources and who did not. And those in need got those resources.

So that kind of supply limitation forces us to live within reasonable limits. And it is a very effective budgetary constraint.

And finally, on the question of improving productivity, what I suggest is that the attack on administrative waste is, in fact, an enormous possibility for increasing productivity.

Between 1990 and 1991 in this country, we hired 98,000 additional clerical and managerial personnel in American hospitals, not one of whom saw a patient.

During that same year, we decreased our clinical work force by 9,000 physicians in hospitals and 61,000 nurses, 9,000 psychologists and social workers, and 11,000 other clinical professionals. That is a plummeting productivity in our hospitals due to the increasing bureaucracy.

Senator DURENBERGER. Can we end it there?

Mr. PERES. Can I just get 2 minutes, 1 minute?

Senator DURENBERGER. One. [Laughter.]

Mr. PERES. Okay. I cannot quote a lot of statistics, but I would like to give you a couple of anecdotes. We hear a lot of back patting about the success of Medicare Part A and the controls.

Well, a couple of weeks ago, I learned of a case of an individual who spent about 8 months in the hospital, a terminal case, a variety of lung problems.

Because of the controls, not the DRG controls, not the PRO controls, because of the controls on the days reimbursed, the family of that individual was stuck with a bill approaching $400,000.

Now, if that is the way the Medicare succeeds, I think that there is a problem there.

We hear a lot about the Canadian budgeting. Well, I think if you look at the actual experience, budgets have typically been overrun very often on an individual-institution basis and on a provincial basis.

And last year I read about in the annual report of a hospital I knew very well the CEO said, "We met our budget. We have a small surplus. The reason we have a small surplus is we had a strike."

Lastly, about 4 weeks ago I got a call from a friend who is a CEO of a hospital in Ontario. He said, "Gee, we only had this 1-percent increase in expenses this year from the provincial government. Our doctors came to us and said, 'Maybe we can get some U.S. business to fill some beds.'"

I think it is kind of telling where people are looking to get the extra money. Thank you, Senator.

Senator DURENBERGER. Thank you all.

Senator DASCHLE. Dr. Anderson, I have had the good fortune, as you indicated, to visit your hospital and I must say I was extraordinarily impressed with the service provided, with the people working there with your leadership.

With the effort underway, if that is any indication of the way public hospitals function in this country, our country is a lot better off.

My question relates to the testimony of Dr. Sullivan, his proposal as he has described it, the Administration's response to the need for comprehensive health care reform.

To the degree that you can given your understanding of the proposal, how would that work?

You are a physician first. You run a hospital second. You are probably in the most credible position to analyze the effects of the proposal as he has described it. Could you do so?

Dr. ANDERSON. Senator, I would commend some of the things that are in the President's plan: the addition of community health centers and the funding of some preventive and public health initiatives.

I think everybody has discovered that these are multiple-dollar pay backs. And yet at the same time, as far as giving empowerment to individuals to use our system, it would be hard pressed to see that happen in the private sector.

In Denton County, TX, the county right north of us, there is the most rapidly growing tax base in our State. It has 33 obstetricians, gynecologists, none of whom accept Medicaid.

I am very concerned this would lead to tiering and it would lead again to bigger public systems and not really lead to any real gain at all.

I think that the majority of that is going to be beneficial to vendors. As I said just putting the patient first, a pay or play is much better for me as a hospital administrator or physician.

And in a way I think this is the case. It is going to be hard for the working poor to take a $500 tax credit and buy anything with it.

They might be able to buy primary care and preventive services, but then what we will do for hospitalization or anything.

They lose their jobs when they come to our hospital and wait all day in line. I think it would add to the lines. And I think we would probably break out into public systems. Community health centers would be the only people who would accept them.

So we better expand the infrastructure because I do not see the private physicians—unless we go to the Minnesota plan.

And if you want to pay $500, you are really taking away money for the doctor or the hospital, but it is going to cost a lot more to care for those patients than that.

Somebody said it is better than what we have today. But to me it is somewhat of an apology frankly. It does build on public health. And I really would emphasize the need to do that, but I do not think it is a solution for people standing in the lines at Parkland.

Senator DASCHLE. What I wanted to devote the bulk of the remaining moments of this hearing to is some way with which the committee for the record and for future debate can sort out, as Dr. Marmor was suggesting, the fact from the fiction, the rhetorical pollution that exists both about our system as well as about foreign systems.

And Senator Durenberger is correct. There is a distracting element to it.

But what advice would you have for us? Assuming all Senators were sitting here this morning to hear what we have heard, how do you sort it all out?

You have some who say the Canadian health experience has really been a disaster. The Secretary of Health and Human Services saying that he believes that as a result of quote, diminished quality, restrictions, and increased rationing.

Number one, how do you sort it out? If you were we, how would one do that effectively in order to ascertain some truthful and objective understanding about the degree to which those systems work and have addressed the same problems that our country is facing today?

Dr. ANDERSON. Senator.

Senator DASCHLE. Yes.

Dr. ANDERSON. There is an old saying of the samurai, "The greatest samurai is the one who first conquers himself."

And while we are talking about the quality of care in Canada and how it is not as good and they oftentimes don't treat hard-to-reach populations, the truth is that many Americans go across the border also to deliver babies, they cannot afford American medicine.

We have people in south Texas that go across the border to Mexico because they cannot afford health care in south Texas.

We have some major problems. We need to look inside. And while we have the best health care in the world and the President says this quite frequently, we do for those who pay; we do not in many of the public hospitals.

Parkland is a hospital that the community invested in.

But Cook County Hospital in Chicago and Charity Hospital in Louisiana would be very different situations if you visit those. And people would not have the same quality of care. But, we all must ration health care everyday.

At Massachusetts General, they ration daily. We do it implicitly now. But the Canadians rarely ration, at least they have made that decision not to do it.

And most of the time the decision to dialyze or not to dialyze a 65-year-old diabetic is made by a physician commissioned to determine whether it is going to be effective or not.

I think that is one of the real myths about this: what is likely to benefit from outcome? I guess I would make the same challenge I have to my friends from Oregon who have brought this debate forward, too, about rationing.

How can we talk about that and debate about that when we have a lot of fraud, we have problems with tort reform, and defensive medicine? And we have not funded the infrastructure things in public health that we know will work.

I would like to see us fill the gap, see what the costs we have in America are, see what the big chances and opportunities, and get together and develop a national health plan and policy bipartisan and attack some of the inefficiencies in our system.

I would tell you, for $817 billion, I would take the challenge today in a single-payer system if you let me also do an infrastructure, tort reform, creating enough primary care doctors, changing the incentives that are out there.

And I would not be sure that I would need that much more money, but you are going to spend a lot more money than that if we just continue to go with the same system.

I think the first step is let us be introspective and not criticize others in the their failings. They are evolving every day. And we need to evolve, but right now we seem to be paralyzed.

And I think the biggest thing we do not have is the commitment to health care has arrived and the commitment to a national health plan is bipartisan.

You cannot solve public health problems in 2-year or 4-year election cycles. You need decades and generations to do so.

Senator DASCHLE. Mr. Peres.

Mr. PERES. I have to agree with Senator Durenberger. I think we have spent a lot of time, a lot of effort talking about the means without knowing what the end is. There is a lot of rhetoric, a lot of truth, and a lot of falsehood both pro and con of foreign systems.

But I think we first need to understand what is it that we want and then we have to figure out the way to get there, not argue the means.

As I said in my remarks, do we want an insurance system, do we want a benefit system? What is the public health role? Is it tied in or not with medical plans?

I mean, those are the issues we ought to be deciding upon. And then decide the way to get there. Because if we continue to argue about is Canada good or not, we are not going to move along any further in the debate.

Senator DASCHLE. But how do you answer Dr. Marmor's point to Senator Durenberger that you really only have two choices?

You have the theoretical model or you have the real model, models experienced by others. And that you are really forced into one or the other set of models in order to determine the effectiveness, the efficacy of a given approach to health care delivery.

Mr. PERES. I think that right now you could look at them as perhaps as two ends of a spectrum. Maybe we end up somewhere in the middle. As I was trying to point out in my remarks, we are not Canada.

There are a lot of things which contribute to the success of their system or the success of the German or any other system which go beyond specifically how they finance and deliver health care.

And I think those are the things we need to identify. We need to say this is the American way of doing things. And this is what we want. I do not know that it is an either-or proposition. As a matter of fact, I do not think it is an either-or proposition.

And, yes, people by and large are satisfied in Canada, but I also know, having family and friends there, you can talk about anecdotes or problems, but I do not think that that benefits the debate.

Senator DASCHLE. Dr. Himmelstein.

Dr. HIMMELSTEIN. I think frankly if there is one thing I would say can help us clarify the debate it is to try and take the enormous resources on one side of the debate off the playing field.

We have at this point some medical care industries that make enormous revenues from the provision of services in the current system. And at this point, they are funding large-scale campaigns on this issue out of those health care dollars.

So the insurance industry from its premiums, from the money that we pay for our health care, is deducting tens of millions of dollars for this information campaign, not to try to enlighten this debate, but to protect their interests. The pharmaceutical industry the same thing.

And I think one of the questions for the American people is to what extent do we want to fund out of what we spend for health care a disinformation campaign as part of this debate. And frankly I think election reform is one of the major issues involved here, too.

We have disproportionate power from the groups that are currently making large sums of money off this system. And as long as we allow them to use that money and power to influence the future of our debate, we will not have a balanced debate on this.

Senator DASCHLE. Mr. Schramm and then Dr. Marmor.

Mr. SCHRAMM. Thank you, Senator.

I would suggest, unlike what Dr. Himmelstein has just stated, that rather than to drive this into a further polarized debate about who is spending what to disinform, it is important to appreciate, that most of the partisans and participants in this discussion do not come with the view to disinform fellow Americans. That is certainly not the case with the insurance industry.

I think one could make the case that there are professors and physicians and hospital administrators who are engaged in advocacy of their positions, without the motivation imputed that there is misinformation as the reason they participate in the debate.

It seems to me Dr. Anderson put us on the right trail when he said essentially the Japanese twist of the Aristotelian view, know thyself.

American society embraces and encourages and nourishes more experts on health policy by a factor of 10 than all the other countries put together.

We know from a clinical standard and from a research standard more from a statistical base and an empirical than any other country by a factor of 5 or 15.

Enormously more is known about our system in the United States than any other place. We have a much higher level of reflection and consciousness of it.

But still there are fundamental questions that are not even part of the debate. And I alluded to several in my direct testimony today.

It seems to me rather shocking in the United States that we proceed with this debate without any difference or clue about the actual health status of this population.

It would seem to me that one of the important and critical questions that we have to ask ourselves is what we are getting for all this money. Are Americans getting healthier?

I would allege on the basis of my hunches and my research, that we have spent another 5 percent of our GDP in the last 15 years without any demonstrable or evident increase in the standards of the health in this population.

There is no increase incremental or any other kind of increase that you could detect statistically in longevity.

You cannot find any increase. And actually there is some decrease in the majority population in the incident of deaths at birth, but these are extraordinarily crude measures.

Now, it seems to me that if we took this debate in the terms of saying: All right. Our objective is to make the American population a good deal healthier.

That would put us in the business of looking at where it was that we spend money to improve health status. The first thing that would put us in this business is looking very hard at the question of what we are buying by way of providers.

We know positively that adding another 100,000 doctors into our present group of 600,000 doctors will not have any impact on the health status of this population. We know this positively.

We know positively in terms of new hospital beds, too. I think there is agreement among our health policy people and physicians and hospital administrators that we do not need new hospital beds.

We know that the epidemic of cancers and so forth are influenced more by pollution of the environment.

We know that we are robbing our preventive health practices, our State health departments, our municipal health departments of the revenues once used to support immunization programs. We do not spend those monies because we are lumping it all into acute delivery.

And I would suggest that one of the most important things we do is basically cut off all the passports to travel out of the country. And say that this is our problem.

We spend much more on a per capita basis than any other country. Given the money that we spend, we ought to be able to craft a highly efficient and equitable system that covers anybody and is still marching towards a goal of making the society healthier as a result of that spending.

Senator DASCHLE. Dr. Marmor.

Dr. MARMOR. Well, the first thing I would do is change the form of the hearings you run. It seems to me that this particular forum is designed to emit noise, create claims, and not to resolve them.

And my suggestion is a very hard one to follow. You are not doing this by accident. But my sense would be this—and to try to keep to the question that you actually asked. You asked, "What should you do to do separate fact from fantasy?"

Well, I think you have one of two choices. One, on the narrow comparative topic that you raised, you might actually inspect what another government agency has done in a fairly serious way: look at who the GAO has written about, Germany and France, and Japan, as well as Canada.

Do not treat that work as the gospel, but treat the GAO as a group that had to live with defending these analyses as reasonable claims

And have a series of panels which are drawn from people who you have some good reason to believe are not only knowledgeable, but are actually committed to defend seriously the truthfulness of what they say.

And have a serious engagement with a set of reports that have already been done. I think the trouble is that claims are made here which are picked up by reporters and then banded about, like, for

example, the claim about Canadian doctors done this morning by Secretary Sullivan.

If Secretary Sullivan behaved that way as a physician, I would be worried for his patients. He did not know what he was talking about. He had to be shown where the reference was. Well, that is not the way to establish the truth about comparative health systems.

My point would be you have got to take into account that with this big an industry, the stakes are huge. With this scale of economic stakes, everybody is going to feel pressure to come up with a position that is comfortable to their own group. That is true of all us, myself included.

The only way you get countervailing intellectual forces is to create an environment in which there is punishment for people misusing their expertise.

When I think about the commission in 1983 on the Social Security, I think about that again as an area where enormous controversy was created. And a set of serious people were given a serious task.

And someone like Robert Meyers, a Republican who has worked on both sides of the aisle, had to come up with defensible claims in a way that changed the ordinary process.

So either between a commission of the kind that you were suggesting or a special set of hearings in which the format differs from the ordinary one. There would not be prepared statements beforehand, but there would be background material given and questions asked and a debate in front of you.

I think unless you do that what happens is that these hearings become devices for ventilating already predigested views. And the consequence is that the populace feels ill served by what is presented to them as a truth-seeking exercise.

I have gone around the country this year. I have been astounded at the anger people feel about the gap between what they are told about medical care and their experience about medical care as insurance unravels.

But they are not in the position to sort out what goes on in, let us say, Manitoba as opposed to Minnesota or in Vancouver as opposed to Seattle or in Montreal as opposed to Boston.

And they are not in a position to make any judgments, for example, about whether constraints and the supply of physicians seem to be important in cost control, the point that Carl raised earlier.

So without overtaxing one's aspirations for exploration of the truth, I think you could set up a framework in which the rewards for presentation here would be somewhat different and in which the preparation for it would be substantial enough so that you would know you had at the table people who were prepared to challenge in a very direct way and defend their challenges.

That is about all I can think of.

Senator DASCHLE. Well, this job is hard enough as it is. It is hard enough if all we had were the facts and a truly objective analysis of what it is that we must do in order to accomplish our goals.

Dr. MARMOR. That alone would be hard.

Senator DASCHLE. That would be hard enough. But this whole issue is so clouded with anecdotal and other kinds of information

that distort the facts and cloud the choices and make our whole job even far more complex.

The obfuscation of information is so incredibly alarming that it really causes me concern.

And I am not just saying one side or the other. As everyone has indicated, a clear indication that as a result of the information presented here, we are not even going to get to first base unless we clear up some of that misunderstanding prior to the time we make these hard choices.

Dr. MARMOR. In every other system that I have looked at among the vast industrial democracies, in every single one before they universalized insurance, they had some kind of commission that settled partly factual questions and brought forward to the governmental decisionmakers some degree of prepared baseline information.

That has been true of every single one of them. The famous Hall commission in Canada is just one illustration. We are backing into universal health insurance. And it may be that we need to do something like the Hall Commission in our forum with our own peculiarities.

But we will never do it completely. We do not have royal commissions. We are not a monarchy. We do not have an old monarchy. We do not have that kind of authority.

The institute of medicine one might have hoped in another context, but that does not seem quite right for this setting and so on. But every one of the CECD countries did something special to prepare for the avalanche of claims about information.

Senator DASCHLE. Dr. Brown.

Dr. BROWN. I would add to what Ted said only that I think that those kinds of hearings in which people who really have studied particular countries or done so comparatively could be very productive. They would be useful particularly if the people who are invited to testify or participate in that debate are not invested in seeing a particular outcome in this country that was modeled after one or another country or not modeled after any other country.

I also think it is obviously important to remember that every system has advantages and disadvantages. And I think for ourselves, the task is to shift through what are the things that we can build into our system or build on or rebuild that will minimize the disadvantages and maximize the advantages, drawing from wherever we feel it is appropriate.

I think that few of us up here would be advocates of adopting another country's system. And that, in fact, is kind of the convenient attack by opponents of comprehensive reform who may often refer to a proposal as a "Canadian-style system" simply to distract attention from the details or the structure of that proposal and focus instead on what may be fairly superficial similarities to another country whose system they are opposed to and where their real agenda may be undermining support for such a structural change.

Senator DASCHLE. Well, this has gone on very long. And I appreciate very much your testimony.

I just have to ask Carl one last question. I have never heard until this morning in your testimony that other countries in other

parts of the world are moving much more towards a private system.

What examples would you share with us in that regard, Carl, to illustrate your point?

Mr. SCHRAMM. Well, certainly, Great Britain is a very important and I think stunning example.

Senator DASCHLE. Great Britain is moving dramatically towards a private health care system?

Mr. SCHRAMM. Well, in the last 10 years, we now find 12 percent of the population of Great Britain covered by private insurance.

Senator DASCHLE. As opposed to what 10 years ago?

Mr. SCHRAMM. Zero percent 10 years ago.

Senator DASCHLE. Zero.

Dr. BROWN. Wrong. Not true. It was 5 or 6 percent 10 years ago.

Senator DASCHLE. Let me just ask Mr. Schramm to finish.

So you use Great Britain as an illustration. Are there any others?

Mr. SCHRAMM. The dramatic points that I was making in terms of the movement in this direction from Lloyds is where I based my fact there. I apologize if I am incorrect on that.

And also in Great Britain is the notion that the insurance capacity, the reinsurance capacity is now trying to rebuild the health planning in Czechoslovakia and in Russia and in several other Eastern bloc countries.

Senator DASCHLE. So you are saying in eastern Europe, they are moving from a governmental system to a private sector system for health care delivery.

Mr. SCHRAMM. Yes.

Senator DASCHLE. And so you got Britain and the Eastern European countries as illustrations of that fact.

Mr. Schramm. Right. We also have evidence from New Zealand and also have evidence of a growing interest, if not, a significant emergence of a reborn private system of co-insurance or wrap around insurance in one of the Scandinavian countries.

Senator DASCHLE. Dr. Marmor.

Dr. MARMOR. The only thing I would add to that is that you have to be careful what you mean by the growth of a private system.

Every one of these systems is struggling with pressures of medical care costs in a period of economic recession. And it is just true that everywhere they are looking around for ways of balancing cost against increased care.

What I think is striking is that misleading implications are easily drawn from their struggles.

For instance, in Great Britain, almost none of the proposed changes would shift the public financing of medical care, but would rather change the relationship between doctors and hospitals and open up some choice for them.

Now, that is an example of public sector competition which has nothing to do with a model of private insurance. Private insurance, in fact, is having a quite difficult time dealing with these changes in Britain.

In the Scandinavian countries, I think it is correct as Carl says that because of some bottlenecks in their publicly-funded hospitals, there has been some experimentation with some add-ons, a kind of

exit alternative. But that is from a 100 percent publicly-funded hospital scheme.

So looking at the adjustments of countries that have already gotten their populations covered and have got their costs roughly in line with their growth of income is very different from the problem we have.

We are looking forward to try to get our house in order. They are looking sideways to see whether they can get in a slightly better order.

Mr. SCHRAMM. I do not mean to mislead, Senator. I do not think we should look at the emergence in Great Britain or Scandinavia or New Zealand or the interest in Russia and say: oh, my gosh, the public systems do not work.

I think it is much more instructive to suggest even hypothetically, let us say, we are returning in 3 years and we find 10 percent of the Canadian population, upper income people, essentially choosing 100 new Federal statutes in Canada that would allow such a change of private insurance protection.

I think Ted is really on the right road. What I think we see emerging there and the caution I would deliver from the observation of the emergence of the private market in these other countries is that in every single one of these countries, the engines underneath that devil us are virtually the same.

They move faster. They had comprehensive government protection. It erodes, just as our own public programs have eroded, because there is not a composite view of exactly how to deal with the over supply of physicians, the over capitalization and decay of hospital capital, the entrance of new medical technology that we lead the world in, but we export to all these countries.

So what I suggest is that the balance that must be struck in any country is that country's to deal with.

And the observation that these public programs may be crumbling, I only offer to suggest that there is no Valhalla in Scandinavia; there is no garden of paradise in England or Canada. They are struggling inside their own problems with the same engines that we face.

Dr. HIMMELSTEIN. But what should be clear when asked this question, "Would you go back to an American-style system or do you prefer to have the Canadian-style system?"

Three percent of Canadians said they would prefer to go back to a U.S.-styled system which one of my Canadian colleagues pointed out to me is their illiteracy rate that is one-fifth of the number who still believes that Elvis is alive in that country. [Laughter.]

Dr. HIMMELSTEIN. So the growth of private insurance in Canada is a non-issue. No political party in Canada is willing to say that it advocates that publicly. And far from 10 percent of the population, a very tiny, tiny minority would even want that to happen.

Senator DASCHLE. Dr. Brown.

Dr. BROWN. I would add that the issues that are being struggled over in these countries are how to control the growth of health care spending, how to redirect and reallocate the spending and the resources that they now put into health care to produce more of the kinds of outcomes that all of us favor, to emphasize things like pri-

mary care, to bring down somewhat the growth of the hospital sector and its ability to endlessly absorb medical care dollars.

That certainly has been the motivation in Sweden. And there is no interest in Sweden in privatizing the insurance system in Sweden.

In England, John Majors had to promise, publicly swear that he would, in fact, strengthen the national health service, not dismantle it, in order to get reelected. And his first announcement upon reelection was that he would fulfill that vow to strengthen the national health service.

In New Zealand where the system was by all accounts insufficiently funded, there was a debate that emerged in the parliament over whether or not to institute a system of private health insurance or instead to raise taxes to support the national program they have.

I was visited just 2 weeks ago by the Director of the Mental Health System in New Zealand who told me that just a couple of weeks before, politicians had cut short what they expected to be a very lengthy and contentious public debate about this issue because the populace was so overwhelmingly opposed to private health insurance and favored an increase in taxes because they felt they got great value for their tax dollars.

And I think that is the lesson that we can all draw from tax-financed public and universal health insurance programs throughout the world: when they produce value for what people and those countries put into them, they have enormous popular support and people do not resent paying taxes to support them.

Mr. PERES. Senator.

Senator DASCHLE. Yes.

Mr. PERES. If I may. And I know you want to end the hearing.

Dr. Himmelstein's quip about the 3-percent illiteracy rate equaling the 3-percent support for private health insurance hit a real nerve.

And I think you asked what can we do and we heard some comments that we should not have the people with a vested interest in the room because they have a vested interest. We should have perhaps—as I think was Dr. Brown or Dr. Marmor said—we should have disinterested experts, perhaps academics.

But I do not know that anybody is disinterested. Maybe they do not get their specific dollars, their salary from an insurer or a pharmaceutical firm, but everybody has an interest.

What I have not heard is let us ask the people. Let us find out what they want out of the health care system. Let us get them to help define what they mean by reform. What do they mean by the national health insurance because they do not agree?

There are some efforts that I know are ongoing to try and do that. I think that that would be a very good first step.

Senator DASCHLE. Well, I think you are right, Mr. Peres. It is a good first step. But I also think we need leadership. We are not going to accomplish what we need to set out regardless of what it is we finally choose to do if it is not from very strong national leadership.

And in my view, it has got to start with the White House. If you want my honest opinion, I do not think we are going to get any-

thing done until we have leadership in the White House that works with the Congress in coming up with a comprehensive solution that will bring us the desired result far beyond that which we heard proposed by the Secretary this morning.

But we have made another contribution to the debate this morning. As I said earlier, I think this has been an excellent panel. I appreciate the testimony, the information provided. Your comments were very helpful.

With that, the hearing stands adjourned.

[Whereupon, the hearing was recessed at 1:25 p.m. to be resumed at 9:30 a.m. on Thursday, June 18, 1992.]

COMPREHENSIVE HEALTH CARE REFORM AND COST CONTAINMENT

THURSDAY, JUNE 18, 1992

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

The hearing was convened, pursuant to recess, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Daschle, Breaux, Packwood, Chafee, Durenberger, and Grassley.

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

The CHAIRMAN. If you would please be seated and cease conversation, then we will get under way.

The American health care system, obviously, is in serious need of reform. I think we are reaching crisis proportions on it. Spending on health care continues to grow at double-digit rates, rapidly outpacing the general growth in our economy.

Millions of Americans are struggling to afford the health care services that they need, worrying whether or not health care will be available when they need it, or when a sick child or an elderly parent needs it.

Agreeing on that is the easy part of it. Agreeing on the solution is a lot tougher. We are getting a great diversity in offers on what various members of Congress and so-called experts in the field think will take care of the problem.

But, nevertheless, we are committed to enacting legislative solutions to these problems, and today's hearings are going to help us do that.

During the last month, the Finance Committee has continued its examination of these issues in a whole series of hearings intended to explore these specific proposals for comprehensive health care reform.

Today's hearing focuses on proposals that would use the Federal tax policy and other incentive-based methods as a means of providing Americans access to health care.

Yesterday we heard testimony from Health and Human Services Secretary Sullivan about the President's proposal; from Senator Kassebaum about her proposal, and pending before this committee are a number of other bills that take this general approach, including S. 1936, a product of the Senate Republican Task Force on

Health Care introduced by Senators Chafee, Dole, and 21 other Republican Senators last November.

Senator Symms has offered S. 2095, the Affordable Health Insurance Tax Act, which makes a number of changes in the tax treatment of health insurance.

At the opening of this Congress, Senator Cohen and Senator McConnell each offered health care plans that include tax credits for the purchase of health insurance. They will join us this morning to discuss their plans.

There is still more to come, including a proposal that would give favorable treatment to employer-based medical savings accounts under development by Senator Breaux.

We will also hear this morning from our House colleagues, Congressmen Stenholm, Andrews, and Cooper. We will discuss the innovative plan put forth by the Conservative Democratic Forum Health Care Task Force.

We have a number of other distinguished health experts who will share their views on these proposals, and I look forward to the testimony of our witnesses. I defer, now, to Senator Packwood for any comment he might want to make.

Senator PACKWOOD. Mr. Chairman, I have no opening statement.

The CHAIRMAN. Thank you. Senator Breaux.

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

Senator BREAUX. Just a brief statement, Mr. Chairman. Just, also, to commend you for your diligence in pursuing this. It is an easy subject. It is something, despit some who say, just fix it, or just do it, that is very complicated and it deserves the time and the attention that you have given to this subject in order to come up with a plan that makes sense and will work and serve the needs of the American public.

I just want to refer, Mr. Chairman, for the record, to the chart that I have here, which really summarizes the medical care savings account legislation that I have introduced. We have a number of co-sponsors on this bill. Senator Coats has a similar bill. He is working with me and has indicated he wants to co-sponsor this one, as well.

This addresses a particular aspect, I think, of the problem that needs to be addressed. If you look at the chart, these figures that are on this chart represent one area of the country. This particular area is in middle America. It is the cities of Denver, Peoria, IL, Cincinnati, and Scranton. These figures are an average of what it costs for insurance in those areas.

The middle line, the $4,500 line, is the cost of employer-provided health insurance in those cities. That is what the employer contributes, per employee, on average: $4,500 for each employee to insure that employee and his family.

Now, if you look on the left, in that area that we are talking about which is similar to all other areas, 94 percent of people who have insurance have less than $3,000 of expenses for health care in a year's time; 94 percent spend less than $3,000 a year on paying for their benefits in health expenses.

What this plan suggests is that let us take that $3,000 that that employer is contributing already in insurance premiums and give it to each employee in a medical care savings account for that employee. And that employee would then have a savings account with $3,000 in it.

Now, the rest of the remaining money the employer would use to buy—which our plan would require him to buy—a catastrophic plan for that employee and his family to cover any expenses over $3,000.

The average cost of that plan in these areas that I am talking about is $1,395. You still have $1,500 left, so that is about a $105 savings from the $4,500. The employer is still contributing the same amount.

Now, here is the advantage of this plan. That employee then has that money to use to pay for his medical expenses. And, as we have seen, 94 percent of the people never spend that much in a year.

That employee would have that money to keep in his account, and if he does not spend it all in the first year, he gets to carry it over. And he gets to carry it over each year that he pays.

If he withdraws it for purposes other than medical purposes, he has to pay income tax on it. He also has to pay tax on the interest that is built up in that savings account.

But say this employee is generally a healthy employee. I have been fortunate. I do not think I have ever had in my lifetime $3,000 of medical expenses in 1 year.

That employee would have the right to keep that account and carry it with him. If he loses his job, he still carries that account with him and is able to use it to take care of his medical expenses.

I think a couple of things happen. Number one, I think there is a problem with people not being as careful as they should be in paying for medical expenses as long as somebody else is paying for it.

As long as Medicare gets the bill, or an insurance company gets the bill, many people want the most, the best, and the most often and there is not a lot of diligence in how they pay for medical care that they use in their lifetime. This would change that, because this money belongs to that employee.

That person would be more careful in how they spend their money, be more selective, seek the best bargains, go to the hospitals that provide care at a good price, and doctors that do a good job at a fair price. So, they become much more disciplined in how they spend their health care dollar because it is now their own health care dollar.

The second thing it does, is to really address the question of administrative expenses. We eliminate red tape by this. Under this plan, when that person goes to the doctor, he does not have to fill out forms. A doctor does not have to fill out forms.

He goes to see the doctor for a $50 or $100 visit; he pays the doctor. The doctor tells him how much it is, the hospital tells him how much it is. You do not have to write up and send off forms, you do not have to use the bureaucratic mess that is now costing us a great deal.

Public Citizen's Report says that from 20–24 percent of American health care costs go for administrative costs. This would eliminate

a large portion of that. Insurance companies have told us that it costs as much for them to process a $500 claim as it costs for them to process a $50 claim.

So, this plan does two things: It gives more discipline to the person in how he spends his health care dollar; secondly, it eliminates the bureaucratic administrative costs for all of those claims of under $3,000 in a year.

And as we have seen, just as one example, 94 percent of the people in this country spend less than that amount per year in health care costs. There is a requirement under this plan that the employer pay for the catastrophic health care plan. He cannot walk out on his responsibility to the employee. So, any cost over $3,000 is covered by a catastrophic plan which the employer contributes to.

And, finally, Mr. Chairman, I would point out, obviously this is not comprehensive. It does not address the millions who do not have insurance. But it is just, I think, one ingredient in a larger part of the solution that I think merits our consideration and favorable reaction to, and would recommend it. Thank you.

The CHAIRMAN. Senator, thank you very much. We will be looking forward to hearing more about your proposal. Our first witness this morning is Senator Bill Cohen, a U.S. Senator from the State of Maine, who has been a student of this subject. We are very pleased to hear his proposal.

STATEMENT OF HON. WILLIAM S. COHEN, A U.S. SENATOR FROM MAINE

Senator COHEN. Thank you very much, Mr. Chairman. I appreciate the invitation to offer a few comments this morning. I might point out we also have an Aging Committee hearing going on in which, among others, Mr. Jack Palance is going to be testifying and talking about the benefit of art and music.

And I am sure it is going to be beneficial for us to learn how it enables him to do three one-handed push-ups during the Academy Awards. I will be leaving shortly to find that out.

The CHAIRMAN. Well, I must say, as we have gone through these proposals, we have been doing a bit of aging ourselves.

Senator COHEN. And not many one-handed push-ups. Mr. Chairman, I think, as you have pointed out very clearly, that the need for health care reform has reached critical portions.

It is, in fact, a moral imperative. We face the ironic situation at a time when expenditures are skyrocketing and most Americans are going without needed care.

As Lester Thurow, the noted economist, has observed, health care is rapidly becoming wealth care as these costs are spinning out of control beyond the reach of the average American.

While we have the best health care system in the world, the very things that make it the best—the scientific breakthroughs, the technology, and the quality of care—also make it the most expensive. And, as costs escalate and climb, access declines.

We are also faced with the ironic situation that Americans want not only cheaper care, they want better care. We are faced with what seems to be an irreconcilable conflict between increasing ac-

cess, controlling costs, and maintaining high quality. And that, indeed, is the challenge that all of us face.

As you pointed out, there are a number of bills pending in the Senate. At least 20 bills have been introduced.

The focus, so far, has been upon the differences that exist between these bills. What I would like to do is focus upon what the various plans have in common, and also voice my objection to the thought that we should resist any sort of temporary or piecemeal approach to reform, regardless of the fact that these reforms are needed, necessary, and, indeed, productive. I do not believe that enactment of these needed reforms would undercut the comprehensive approach that might be agreed upon next year, the year thereafter, or whenever. And I would like to go on record as being strongly in opposition to that particular view.

I would point to today's editorial in the Washington Post that endorsed the proposal that you currently have pending before the Senate and add my own support.

I believe we ought to move forward with whatever pieces of the puzzle that we can adopt that will prove to be beneficial and productive in the effort to improve the health care system.

I would like to focus just quickly upon a number of the common elements. For example, a common element of both Republican and Democratic proposals is insurance market reform to make coverage more available, affordable, and predictable, particularly for small businesses.

Ironically, the very people who need the care most are the ones who cannot get the insurance, and, therefore, are excluded from the system. The insurance companies have to stop competing with each other about whom to exclude and start concentrating on how to make affordable policies available to all Americans. And I believe that your proposal moves very much in that direction.

It is also estimated that as much of a quarter of the uninsured lack coverage because they have been priced out of the market by increases in State-mandated benefits.

Most of us agree that it is time to preempt the more than 800 specific State-mandated benefits in order to make affordable basic benefit packages that emphasize primary and preventative care available to small businesses and individuals.

Most of us agree that it is time to make insurance more affordable for self-employed individuals and their families by granting them the same tax benefits currently granted to big business—to equalize those tax benefits or to come as close as we can to equalizing them.

We all agree that we could reduce administrative costs by as much as $100 billion a year, by replacing the more than 1,100 insurance forms that clog the system with a simplified, standardized electronic claims processing system.

We agree that it is time to reform the medical liability tort system which spends more on legal overhead than on compensating victims, and which adds an estimated $20 billion a year to the nation's health care costs.

There is also agreement that increased funding should be provided for outcomes research to establish which drugs and procedures are most effective under which circumstances to improve

quality of care and to eliminate the costly practice of defensive medicine.

And most of us are concerned about the proliferation of expensive medical equipment and high-tech machinery that has contributed to an equally dazzling explosion in health care expenditures.

These services can, in fact, be delivered more efficiently and effectively by allowing cooperation between hospitals rather than competition, and without fear of being sued by the Justice Department for violating antitrust statutes.

I have introduced as part of my own measure a bill that would allow hospitals to cooperate and share technology without fear of prosecution.

And, finally, we all know that health insurance alone is not going to ensure good health. Americans have to be encouraged to engage in healthy behavior and to accept more responsibility for their physical well-being.

Investments in health promotion and prevention offer returns not only in reduced health care bills, but longer life and increased productivity. As Dr. Michael Creighton has observed, the future of medicine lies not in treating illness, but in preventing it.

So, Mr. Chairman, these concepts, which are all in my proposal, have been endorsed by the administration. They are in your proposal, they are in the Republican Task Force proposal, and they are also in the Mitchell-Rockefeller proposal.

So, I would urge the committee to fix upon those common items that we can all agree upon and move as quickly as possible on them. Not delay until next year, as some have advocated, until we can have a total comprehensive bill that all of us, or a majority can adopt.

I think there are things that we can do and should do as quickly as possible and focus not upon what divides us, but upon what unites us. And I thank the Chairman for this.

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

The CHAIRMAN. Senator, I sincerely appreciate your comments there, and I strongly share them. We have passed, with good bipartisan support, our Better Access to Health Care bill. And it does begin to take care of the problem of people working for small business.

You are seeing a situation where the premiums continue to mount and a small business person raises the deductible, then the co-insurance, then they drop the dependents, and then they drop the policy altogether.

You are seeing insurance companies come in and cherry-pick and say, we will take 24 of your people, but we are not going to take her because she has a heart condition. And that is the person that may need it the most.

We are seeing job lock because employees cannot change jobs because they have a child that has leukemia, someone has a bad back, and they are afraid they cannot get health insurance in the next job that they might take.

All of those things we have addressed and we can make a major step; not a final one, by any means. But we are going to offer some relief to millions of people and some security of health insurance

accessibility as we work toward comprehensive health care reform. So, I strongly agree with your views in that regard. Senator Packwood.

Senator PACKWOOD. No questions, Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. No questions.

The CHAIRMAN. Thank you very much.

Senator COHEN. Thank you very much, Mr. Chairman.

The CHAIRMAN. We appreciate it. I understand that Senator McConnell has had a conflict with another committee and will not be able to present his testimony. I call, now, on Senator Dan Coats. We are very pleased to have you this morning and look forward to your testimony.

STATEMENT OF HON. DAN COATS, A U.S. SENATOR FROM INDIANA

Senator COATS. Mr. Chairman, thank you very much for the opportunity to briefly speak to you this morning. And Senator Packwood and Senator Breaux, I thank you for this opportunity.

You are going to be hearing very shortly from a good friend and a good Hoosier, J. Patrick Rooney, who, I think more than a year ago, introduced me to a concept that I think holds a great deal of promise in terms of dealing with the current problems we have with access to care, and, particularly, cost of health care.

That concept has been tested and modeled and I have talked to numerous people engaged in the health care field throughout the State of Indiana and found a great deal of receptivity and excitement for the concept, and I would like to just briefly present it.

It is very similar to what Senator Breaux has introduced today. It is called HealthSave. I introduced the legislation on April 7. I have seven Senators co-sponsoring it here in the Senate.

I was attracted to it because it was, of all the plans presented to me—and I have spent, now, more than a year talking to administrators, doctors, nurses, providers, users, employers, insurance people, and others, trying to get a handle on what has turned out to be a very complex problem—a plan with the most promise in terms of achieving real savings.

And it does so because it recognizes a very human behavioral idea. If if we fail to recognize this idea we will only have paper savings and not real savings.

It is a very basic concept—if you give the consumer of health care an incentive to live a healthier lifestyle and to be a wise shopper for health care costs, that incentive will produce real savings. And HealthSave does that.

Its concept is very simple. It takes the IRA concept and creates medical savings accounts. It allows an employer to create for the employee a medical savings account of, say, up to $3,000 per year.

And the employee, or the owner of that account, to the extent that they can save money and not spend it on health care expenditures, the money accrues interest. The money is their property. This is a very basic human incentive to, I think, taking better care of yourself, looking at preventive care, and being a wise shopper.

Now, the concept that HealthSave incorporates is based on the fact that the average employer—at least in the mid-West—cur-

rently spends about $4,500 a year in health care expenditures, for the purchase of a policy for an employee and their family.

Now, we know that we can purchase roughly a catastrophic coverage policy for around $1,500. I am just using rough numbers here, Mr. Rooney can offer the actual actuarial numbers based on research.

But the employer can purchase for the employee and their family a catastrophic policy of $3,000 limit, which will cover all expenses over $3,000. Then, subtracting that from the $4,500, take the remaining $3,000 and give it to the employee in the form of a medical savings account.

To the extent that that employee and their family do not use that $3,000, it accrues. In my bill, on a tax-free basis, and in Senator Breaux's bill, on a taxable basis, but it accrues to that particular employee.

So, what does this motivate the employee to do? He and his family suddenly become preventive-conscious. Because, to the extent that they can modify their diet, their health habits, their exercise habits, their smoking, their drinking, whatever they can do on a preventive nature, they end up saving money.

Secondly—and maybe just as important, if not more importantly—they become shoppers for health care. And we move from a concept of, it does not matter what I spend because someone else is picking up the cost, to it does matter very much what I spend because, to the extent that I do not spend it, that accrues as savings to me and my family and is available, then, upon retirement, for purchase of long-term care coverage, for protection against major medical expenses, and, under my bill for retirement; under Senator Breaux's bill, just for the first two.

From that standpoint, then, the individual becomes a player in the system. And without making the user a player in the system, I do not think we will get away from this problem that we currently experience, and that is, someone else is paying for it, I have paid my premium, I am going to run it up to my deductible as fast as I can, and then everything after that I am not going to worry about. It is just human nature to do so.

But, if that money becomes mine, or that money can accumulate and become mine upon retirement, I am suddenly going to start asking some very important questions. Do I need this procedure? Is there a cheaper prescription medicine available to treat me? Can someone else do it cheaper? Is this really necessary?

This is the way we shop for cars, or refrigerators, or microwaves, or VCRs, or televisions and most everything else. The one area we do not ask questions and compare prices and actually shop is in the medical care field because it is picked up by someone else.

So, HealthSave, which I introduced on April 7th, has seven sponsors. I am going to co-sponsor Senator Breaux's bill. We are going to try to work together to achieve some bipartisan support for this. It is the concept that I think is important.

J. Patrick Rooney is going to explain that, and I am proud that a Hoosier has devoted so much of his time in talking to Senators, traveling around the country trying to encourage a concept that I think is very important. And I look forward to his testimony, and

I think you will find it very interesting. I appreciate the opportunity to discuss HealthSave with you this morning.

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

The CHAIRMAN. Thank you very much, Senator. It is an interesting proposal. Senator Breaux has discussed it, and apparently we are going to get further testimony on it. So, I am very pleased to have you present it. Senator Packwood.

Senator PACKWOOD. No questions, Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. I will take just a moment to thank Senator Coats for being here and for working on this plan. I did not understand it in the beginning. Employers can already do this, but the difference is, when they give, sav, that $3,000 to the employee, there is an incentive for the employee to spend it all. Because, after the end of the year, whatever is not spent, it reverts back to the employer under the current tax law.

Our proposal is different because it allows that employee to accrue those savings, and, instead of being an incentive to spend it all, it is an incentive to be more careful in how you spend, knowing that if you do not spend it all, that it reverts over to the next year, and the next year, and builds up each year thereafter until you have a real big nest egg that can be used for retirement, could be used for long-term health care when that person reaches that stage in his life when he needs it.

So, the real difference in the tax situation is that a person who has this account is not encouraged to spend it all, but, in fact, is encouraged to spend it more wisely and allow it to build up each year. And I think, from a tax standpoint, that is the change we are talking about.

In our bill, the interest build up, which dramatically reduces the cost, is a taxable income to that employee. The $3,000 contribution is already deductible by the employer, so there is no change there. So, I think it is a good concept. Congratulations to the Senator for working on it.

The CHAIRMAN. Senator Durenberger, for any comments you might have.

Senator DURENBERGER. Thank you, Mr. Chairman. I appreciate very much the contributions to my learning that all of my colleagues have made.

And my old friend, Pat Rooney, who really began as a student working with my father who was a teacher and a coach at St. Johns many years ago—he is much more than a Hoosier, Senator Coats.

Senator COATS. Well, Pat is a Hoosier. I do not care how you describe him; we are going to claim him.

Senator DURENBERGER. All right. Well, we will split him.

The first question I would like to ask is, what is the value you see in hanging onto the employee in this whole system?

There are people—I think the Heritage Foundation is one of the best examples and you are probably generally familiar with their proposal—who say, "What is the point of keeping the employer in here, anyway? Have the employer pay cash the old-fashioned way—

wages and salaries—to employees and let the employees then make decisions about where they are going to get their health insurance.

Have you come to this particular approach, which seems to me to be kind of half-way in between those two? Have you come to this because you see some particular value in not taking the employer out of the loop, but keeping them involved in some way?

Senator COATS. Well, I see no reason why this cannot be applicable both through an employer-paid plan and an individual plan. And I think we could easily provide this concept to both of those plans, just because there are so many Americans that are currently—it is just sort of ingrained in all of our minds that one of the benefits available through employment is an employer- provided health insurance plan.

I think it would be a radical notion at this point in the debate to simply say we are going to scrap all employer-paid insurance plans.

Senator DURENBERGER. But you see this as working under either circumstance.

Senator COATS. There is no reason why this cannot work in a dual system. Employers can choose it if they wish. In fact, we are working to try and incorporate this for those that are currently not covered by insurance, or underinsured, an we are working with the administration in terms of their voucher plan so that those vouchers could be used to set up individual medical accounts. And that takes it, then, beyond just those currently covered under employer plans and makes it available to uninsured.

Senator DURENBERGER. That gets me to the second question, and maybe partially answers the second question, which is the traditional way of looking at these medical savings accounts is that they are available to some—those with a little bit of spare cash on the margin—and they are not available to a lot of other people.

But if you tie it together with some kind of a voucher plan or a tax credit. I suppose you are getting a little bit closer to leveling out the economic disparity.

Senator COATS. Absolutely. Because this question of access has to go together with cost. We have to deal with the dual problems. And if we go forward with, say, a voucher type plan or where a certain amount of credit is provided, there is no reason why an individual who is not currently covered under an employer's plan, or perhaps not even employed, could not take that voucher or that credit that is available to that individual and take it to a bank or financial institution that is offering the medical savings account and use it to set up his or her own account.

We might even have a plan whereby they could also purchase the catastrophic. I think that the purchase of the catastrophic is important here—the umbrella coverage—because without it, you continue to have that problem of, a major lifetime, high-cost illness coming along and taking out a lifetime of savings and a lifetime of earnings and assets? The comfort of having an umbrella policy providing coverage for catastrophic illness or cost, I think, is an integral part of all this.

And, then, underneath that, you have your basic costs that most families incur every year. You have the protection and safety of the

catastrophic, but you also have the incentive of being health conscious and cost conscious.

Senator DURENBERGER. I think the only other thing I am left with a concern about—and I ask this question to everybody eventually—is the notion that somehow if people are paying the first $1,000 or $2,000, they are going to change the system in some way. In my experience with the system, I am not sure it is going to happen.

I think we need the George Halvorsons in here. If you buy George's plan, and you let George ask the questions about alternative drugs, and you let George ask the questions about alternative procedures, you are going to come out a lot better than Dan Coats taking one of his kids in there and arguing with a doctor whom he has been seeing for a long time. I am certainly not convinced that, because I have to spend my own dollars, that automatically I am going to be able to cut a deal with a doctor who is going to do something better for me for less money.

Senator COATS. Well, I base it on the fact that, in my own personal experience and the experience that I think is true to most individuals, if we can personally profit or save from decisions that we make, we are much more inclined to be involved in the decision-making process than if someone else is doing that. I look for the best deal when I am out buying a product, if I know it is going to save me money. It is the difference between owning a house and renting a house.

If you rent a car or a house, you just naturally do not take care of it. You are not as conscious about doing things up front that will save you money later on—you know, that old, pay me now, pay me later concept—as you are if you own it yourself.

Senator DURENBERGER. Right.

The CHAIRMAN. Thank you very much, Senator. We appreciate your testimony this morning. Next, we have a panel that consists of Congressman Charles Stenholm; Congressman Michael Andrews; and Congressman Jim Cooper. If you gentlemen would come forward, we would be pleased to——

Representative STENHOLM. Mr. Chairman, we have had a vote call. Would it be possible for us to let someone else go and us come back?

The CHAIRMAN. Yes, of course. We will do that. Next, we have a panel consisting of George Halvorson, who is the president and chief executive officer of Group Health in Minneapolis, MN, on behalf of the Group Health Association of America; J. Patrick Rooney, who is president and chairman of the board of the Golden Rule Insurance Co. If you will come forward, please.

Senator DURENBERGER. Mr. Chairman, if I may, let me thank you for calling both of these witnesses. They both happen to be very dear and personal friends of mine, and people that I admire greatly for their expertise. I compliment you on your wisdom in asking them to come and testify on this issue.

The CHAIRMAN. Mr. Halvorson, if you would proceed, please.

STATEMENT OF GEORGE HALVORSON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH INC., MINNEAPOLIS, MN, ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA

Mr. HALVORSON. Thank you, Mr. Chairman. Good morning, Mr. Chairman, Senator Durenberger, members of the committee. It is a great honor for me to appear before you to talk about this extremely important topic.

My name is George Halvorson. I am the President and CEO of Group Health, Inc., a 320,000-member staff model HMO located in Minnesota.

As a staff model HMO, we own and operate our own clinics and care facilities, employing physicians, nurses, lab technologists, pharmacists, et cetera. We currently have about 3,800 employees, and 3,500 of them deliver care.

I am also the Chair-elect of the Group Health Association of America, GHAA. GHAA is the nation's largest and oldest trade association for HMO's and GHAA members enroll most of the 38.6 million people in this country who are members of HMO's.

I was also a member of the Minnesota Health Care Access Commission that helped to create the HealthRight legislation that we hope, in Minnesota, will bring down the cost of care for us. And I will be a member of the new HealthRight Commission that is being established to help accomplish that goal in Minnesota.

I am here today to make a couple of comments about the reasons why this Congress should consider the inclusion of HMO's in any solution that you develop for the health care cost problems.

And then I would like to offer a thought about the underlying flaws that will need to be corrected in the health care financing system before any of the proposals that you are considering will have any chance for success.

Let me begin with the performance of HMO's. Mr. Chairman, HMO's work. HMO's deliver more benefits for less money than any alternative form of either health care financing, or delivery.

In 1991, for example, according to a national A. Foster Higgens study of U.S. employers, employers spent 14.7 percent per employee less for HMO coverage than they did for traditional health insurance coverage for their employees.

That 14.7 percent savings is even more impressive when you consider that HMO's offer much more comprehensive benefits than traditional insurance with an actuarial value ranging from 15 to 25 percent higher than traditional insurance. The difference in the insurance world is paid out of pocket by the patient.

So, we have a proven track record of providing more health care for less money, and even the American Medical Association last week publicly acknowledged our success and our value.

HMO's also have the potential to significantly reduce the cost of administering health care. One of the problems of health care delivery in this country is the amount of money that is being spent on health care administration.

Well-structured HMO's can operate at administrative overhead levels that are 40–50 percent below levels that are common in the insurance industry.

Our plan, for example, has a pure administrative cost of about 7 percent of total expenses. Our sister plan in Seattle, Group Health Cooperative of Puget Sound, does even better, with an administrative cost burden of only 5.1 percent. Those numbers, as you know, compare very favorably with the cost numbers from the Canadian single-payer system and we offer much more comprehensive services.

The largest HMO in this country, the Kaiser Foundation Health Plan, puts even the Canadian system to shame, with an administrative expense in 1990 of only 2.5 percent.

So, in other words, you have in front of you a mechanism that can deliver more care for less money while wasting fewer dollars on administrative overhead. And I urge you to include us in your planning for the future.

Before closing, I would like to make one final comment. Most of the health care reform measures offered to date focus on fine-tuning the current health care delivery system by changing underwriting rules, modifying the tax policy, or mandating the availability of coverage from either insurers or employers.

Those approaches all have their place, but they simply basically polish the wart. The real underlying problem is that we have a dysfunctional health care marketplace and we reward the wrong kinds of health care performance. Any economic system does exactly what it is paid to do.

And we pay our health care providers for units of care, technological complexity, and heroic medicine. We do not pay for improved health care outcomes or cures.

There are more than 7,000 billing codes in our payment system for units of care and procedures, and there is not one single billing code for a cure. This is a situation that creates many of the problems that exist in the health care delivery system today.

And we do not even let the consumers know which providers do a better job of providing cures so the consumers themselves can make knowledgeable choices. The consumers do not know which health care providers give them the best chance of surviving a heart attack, avoiding pre-term birth, or having cancer detected at an early stage while it is still curable.

These are all measurable results and consumers should know those responses. The differences are significant, but they are not available to the consumers. The health care delivery system does not currently pay for results.

As a result, we basically, in this country, have a non-system with hundreds of thousands of health care providers sub-optimizing on a daily basis and not functioning as a health care system.

We will not achieve better health care efficiency in this country until we pay for efficiency. We will not achieve better outcomes until we pay for outcomes.

Every proposal in front of you simply fine-tunes the current inherently flawed system and continues to create the inherently perverse incentives of that system. Thank you, Mr. Chairman.

The CHAIRMAN. Do you need to make any further comments in summary, or have you finished?

Mr. HALVORSON. Well, basically, my final comment would be that health care needs to be delivered through a system of care with a focus on outcomes.

And, as long as we continue to treat health care as a cottage industry with independent providers focusing on their economic incentives, and as long as we do not pay them for the outcomes of the process but only pay them for the cost of the process, we will not achieve efficiency.

And every proposal that I have seen continues to use fee-for-serving scorekeeping as a mechanism for determining health care costs. As long as that system stays in place, then the incentives of the providers will be in direct conflict with the incentives of the buyers.

The CHAIRMAN. All right.

Mr. HALVORSON. That needs to be changed.

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

The CHAIRMAN. Mr. Rooney, we are looking forward to your testimony.

STATEMENT OF J. PATRICK ROONEY, CLU, PRESIDENT AND CHAIRMAN OF THE BOARD, GOLDEN RULE INSURANCE CO., INDIANAPOLIS, IN

Mr. ROONEY. Mr. Chairman and members of the Senate Finance Committee, my name is Pat Rooney. I am chairman of the board of Golden Rule Insurance Co. and I am here today to talk about medical care savings accounts.

In a report issued last year, the Congressional Budget Office said that the normal discipline of the marketplace does not work in regard to medical care because, as soon as we go through the deductible, we are all spending somebody else's money.

The function of medical care savings accounts is to get medical care spending under control and to restore the normal discipline of the marketplace.

Here is an example. It is already established that the average spending for a family of employer-purchased group insurance is $4,500 a year. You can buy a catastrophic policy that will pay everything for about, I think it is $1,395 a year, but I use $1,500 as a nice, round, convenient number.

But if you did that, bought for the employee the policy that would cover everything above $3,000, guess what? You would have $3,000 left that could be put into a medical savings account for the employee and family each year.

Now, if the employee had a major expense, like $30,000, the employee would be home free because the $3,000 would cover the first $3,000, and the employer's catastrophic policy would cover the next $27,000. But in most years, the employee's family will spend a lot less than $3,000 a year.

Under present law, the employer can do the same thing that we are talking about. The employer can create a medical care savings account for the employee and put $3,000 in it.

Under the present law, however, the use-it-or-lose-it rule would apply. And, as a result of that, since the employer is contributing money that the employees know is attributable to their income, the employees hasten, at the end of the year, to use the whole thing

up, whether they need it or not. They have no reason to spend the money wisely. With the medical care savings account, the same money goes to the employee that the employee can use for medical care.

And, at the end of the year, any money not spent is rolled over to be accumulated for the benefit of the employee and family, just like an IRA, which can be used for retirement, and can be used for long-term care and can be used to pay the COBRA premium if the employee loses his or her job and needs to have a fund with which to continue insurance until the employee gets a new job.

If we do that, there is no question. It will knock a big hole in what is currently being spent on medical care. You know, though we talk a lot about high-tech medical care, the fact is, the majority of the spending is on medical expenses below $3,000.

In the United States, in most communities—excepting Chicago, New York, Los Angeles, some of the very high-cost places—only six out of every 100 people will spend as much as $3,000 on medical care.

And, so, a major source of the saving in the medical care savings account is a saving on insurance administrative costs. Insurance is not an efficient place for small claims, and that is why we would propose to establish the medical care savings account, let the employee have the money, let the employee spend the money for the small claims.

Now, there are two additional advantages. One, that I have already mentioned, the medical care savings account, is portable, would belong to the employee, and when the employee lost the job, this would create a fund with which the employee could continue to pay premiums to the former employer, under COBRA, and stay insured.

The other advantage is for the low-income employee. The low- income employee today has a deductible, and, at the beginning of the year if the child has an ear infection, the employee has to come up with the deductible out of their own pocket.

Or, if the employee wishes to get preventive care for a member of the family for immunizations, generally the employee has to pay for that out of their own pocket.

If we had medical care savings accounts, the money in the medical care savings accounts could be used to pay for the first dollars of medical care. With that, I am finished. Thank you.

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

The CHAIRMAN. Thank you. Mr. Rooney, I do not have a lot of confidence that if you have a child about to come under the knife, you do a lot of bargaining with the surgeon about what the price is going to be, if I may.

Mr. ROONEY. Senator Bentsen, I have some hearing loss.

The CHAIRMAN. I have been through a lot of this testimony, but I think I understand human reactions rather well. I think what you look for is what you hope is the best care for that loved one. Price becomes very secondary, and that is what concerns me, frankly, in this kind of an approach.

The other thing I look at is an actuarial number that has been given to me. You are talking about businesses currently paying $4,500 for a family of four, with a $250 deductible, and that under

your plan you would have a policy you would sell with a $3,000 deductible for only $1,500.

The actuaries tell me that the insurance company cannot sell that policy with a $3,000 deductible for only $1,500. They argue it is not possible to cover the risk.

They say it is more likely that that policy with a $3,000 deductible will cost about $2,400, and that, instead, you are putting only about $2,100 into the employee account. Tell me what your argument would be the actuaries on that one.

Mr. ROONEY. I am sorry, Senator. Your last statement I did not hear.

The CHAIRMAN. I am trying to understand how you would respond to what I have been given in the way of numbers by some actuaries who say that once you get a $3,000 deductible, that it is not that simple to just say, then, the extra amount is going to be $1,500, and that is the premium you charge. They argue that it is going to cost about $2,400 to cover that risk. How would you respond to that?

Mr. ROONEY. That is simply not correct in most of the country. There are some high-cost areas of the country in which the whole thing, all of the numbers go up. First of all, the $4,500 is no longer $4,500 in New York; it is probably $7,000. So, you would have to ratchet everything up.

But our number of $1,500 will work in Heartland, U.S.A., Cincinnati, Peoria, Denver, Richmond, VA, places of that sort. But it is correct that there are some high-cost places where both the $4,500 is higher and the $1,500 is also higher.

If the premium for the present insurance is $7,000 a year, you could actually subtract $3,000 for the catastrophic policy and you would still have $4,000 left. And all we have to do is fund the medical care savings account to the tune of $3,000.

The CHAIRMAN. Let me get another point because of my time limitations.

Mr. ROONEY. Go ahead.

The CHAIRMAN. If all employers adopted your approach, then it seems to me your company and other private insurance people would be in the catastrophic business, catastrophic care coverage alone, in a market like that.

Would you be willing to accept that Federal regulation would require insurers to cover all individuals, guarantee the renewability of policies, charge premiums that are not based on experience-rating of individuals? No more cherry-picking. How would you respond to that?

Mr. ROONEY. Well, that covers a lot of subjects.

The CHAIRMAN. No, it is pretty basic. Are you going to allow that kind of Federal regulation under your proposal?

Mr. ROONEY. One of the things that would be involved in the higher deductible is that it certainly does minimize the risk of substandard people. For example, a person with diabetes might normally be uninsurable.

But if the insurance starts at $3,000 where the person is self-funding, the needed care to maintain proper supervision of the diabetes, in most instances, the existence of a $3,000 deductible makes the diabetic normally insurable.

So, my simple response is going to a portion that is self-funded with a catastrophic portion on the top makes underwriting much simpler. In our case, by the way, also, we are working on such a product.

The CHAIRMAN. Yes. But I do not believe that that is an answer to what I have asked you. Would you, under those kinds of conditions, be willing to accept the Federal regulation where you had to provide coverage to all people without exception in that regard?

Mr. ROONEY. Yes.

The CHAIRMAN. You would. All right. Mr. Halvorson.

Mr. HALVORSON. Yes.

The CHAIRMAN. One of the points Mr. Rooney makes about managed care was made at yesterday's hearings as well. And there is a certain amount of administrative overhead associated with reviewing the medical treatment of individuals in deciding which care is appropriate or not appropriate. How would you respond to what Mr. Rooney contends is an advantage of his proposal?

Mr. HALVORSON. The advantage being that there would not be that administrative overhead?

The CHAIRMAN. Yes.

Mr. HALVORSON. I think Mr. Rooney's advantage is seriously flawed at several levels, one of them being the fact that consumers will not understand how to purchase care appropriately; there is no sense of the value.

Another is that the care will continue to be purchased through non-systems, and health care is much too complicated today to be delivered through a non-system.

The third flaw is that 40 percent of the people incur 4 percent of the cost; 4 percent of the people incur 40 percent of the cost. For the 40 percent that are now non-users who now incur zero claims cost, and, therefore, zero burden to the health care delivery system, under this proposal, each of those people would suddenly become a $3,000 expense.

You have to save an awful lot of money if you took 40 percent of the people and turned them into $3,000 expenses. So, I think the proposal has some serious flaws in a number of areas, not the least of which is the fact that it does not rely on any particular efficiency in the care system, and relies on individual consumers to somehow determine which care provider would be the most efficient.

That information needs to be made available to the American public, but it is complicated and it cannot be made available on an individual provider basis, and it certainly would be something that would be beyond the ability of any individual consumer to determine.

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. Let me ask Mr. Rooney, although, Mr. Halvorson, if you know the answer to this, you can help me. There is a very bright young woman named Debbie Steelman who knows the health business well.

She was in the Reagan Administration and she is a consultant around here who has testified many times. She is now in her own business; she is self-employed. So, she can only deduct 25 percent of her insurance premium costs anyway.

She tried to buy, individually, a policy with a $5,000 deductible with catastrophic coverage above it, and she said she could not buy it; she could not find it. She could afford the first $5,000, she would pay the first $5,000. She wanted to be covered. Is it true that those policies are hard to find, or impossible to find?

Mr. ROONEY. That is correct. They are.

Senator PACKWOOD. Why is that?

Mr. ROONEY. Well, one of the reasons is the problem of regulation. We used to offer a policy with $5,000 and $15,000 deductible.

In the transactional costs of dealing with insurance departments all over the Nation, we found that for individual coverage it is easier to concentrate on policies with lower deductibles. We offer today policies with deductibles from $250 to $2,500. We are not, today, offering a $5,000 and $15,000 deductible, though we used to. Now, we are planning to do so again.

Senator PACKWOOD. When you say the transactional costs, you mean just qualifying your policy in the State.

Mr. ROONEY. That is right.

Senator PACKWOOD. And that the market for a policy is so small that it is not worth the trouble?

Mr. ROONEY. That is right.

Senator PACKWOOD. All right. Mr. Halvorson, let me ask you about managed care. We have had some witnesses and others who have not been witnesses. I think of Mike Peevey at Southern California Edison who has a big enough company that they are trying managed care in the company.

And he indicates that they do quite well at first, but then the savings disappear after awhile and they are finding their costs going up just as much as before they had managed care. They are starting from a lower base, but they are now escalating up again. Is that a typical experience?

Mr. HALVORSON. I think the disparity between the managed care costs and the standard insurance costs are continuing to increase. I think we are seeing that the upward cost trend in managed care is less than the upper cost trend in standard insurance.

But we compete in the same macro-environment, so when we hire surgeons, we hire surgeons in the same environment where they have fee-for-service reimbursement available to them. And what we need to do is basically change that overall macro environment in order to achieve efficiency.

In order to achieve maximum efficiency, we need to create a system where the providers function in a way where they are rewarded for improving health care outcomes, not for performing procedures.

And as long as they are rewarded for performing procedures and rewarded very well, we will see a system where we have to hire and compete against that particular environment.

Senator PACKWOOD. Let me ask you a question about the Hawaiian system, because the Governor was here to testify a couple of days ago.

And, of course, there they have an employer mandate. And you cannot opt out of it. It is not play-or-pay, it is play. And it is community-based and statewide. And you do not have any variances between Lahaina and Honolulu, nor in ages.

The Governor says it has worked out very well to restrain costs and it is kind of an Alain Enthoven concept. The competition is among the insurance companies to write it, and it is to their benefit, obviously, if they can keep their costs down because the premiums trail pay out. Is there anything wrong with that concept?

Mr. HALVORSON. That is an excellent concept. The single biggest barrier to health care reform in this country at the State level is ERISA.

Senator PACKWOOD. He mentioned that. Yes. And it is becoming a bigger and bigger problem.

Mr. HALVORSON. It is a massive barrier.

Senator PACKWOOD. Yes.

Mr. HALVORSON. I served on the Health Care Access Commission in Minnesota; before that, the Regulatory Reform Commission. Every time we came up with a solution that would work for health care costs in Minnesota, we discovered that we could not apply it to the 40 percent of America that is self-insured.

Senator PACKWOOD. Yes.

Mr. HALVORSON. And, so, we have gone through some fairly circuitous approaches to come up with solutions. If you could do a single thing this year that would make a difference in health care costs, it would be to reform that particular provision.

Senator PACKWOOD. I have heard that from person after person. Mr. Rooney, let us go back to these medical savings accounts again. You are a 35-year-old woman, you work at Woolworth's in Bend, Oregon. You are lucky if you make $15,000 a year.

Mr. ROONEY. I agree.

Senator PACKWOOD. So, the employer, instead of paying, I doubt if it is $4,500 in Bend, assuming it is the woman, her spouse and kids; I do not know what it would be, but they change it and he says, Sally, I am going to put $3,000 into a medical savings account for you and you are to pay your medical expenses out of that. Then I will buy you a policy that will cover expenses above $3,000. And, at the end of the year, Sally, if you have not spent it, you would get to keep it, tax free.

It would seem to me that that is a tremendous incentive for Sally to not undertake any kind of preventive care or just to avoid the doctor until she is in terrible shape because she would like to have the $3,000 tax free.

Mr. ROONEY. Is that a question? Shall I respond?

Senator PACKWOOD. Yes.

Mr. ROONEY. All right. That is a possibility, and that, indeed, may happen. But compare it with the present situation. In the present situation, that same Sally, if she has insurance at all, she probably has a policy with a $250 deductible.

So, if she is going to get preventive care or she is going to take the child with an ear infection to the doctor at the beginning of the year, she has to pay the whole thing out of her pocket.

And if we had the medical care savings account, there would be a fund available to pay the first dollar of medical care. And this Sally, who may be a single mother with a couple of kids, it will be a big help to her, compared with the present situation.

Senator PACKWOOD. I understand that. I just think she would be tempted to save it if she could.

Mr. ROONEY. Well, all right. Today she may not be able to pay it herself.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Breaux.

Senator BREAUX. Particularly, that true, I would say to Senator Packwood. I mean, I remember when we had young kids at home. I had four children and we had about a $300–$400 deductible for each one of them.

And then I would get one finally up to the $400 deductible and I said, man, now the insurance is going to pay all my bills. And the next kid gets sick and we start back from ground zero and work up to $400. The third kid got sick.

I had to start working from ground zero for every kid before the insurance company ever paid a darn thing. I said, why am I paying this insurance? Because I am just paying deductibles for all my kids. And starting out, that is a difficult thing to do. And I think the savings account would have the first dollar paid for for every child in that family. I mean, the money would be there. It would be available.

Let me just ask. We have got two competing philosophies here. Mr. Rooney, you are saying that the individual has enough ability to determine how to shop for medical care in this country and get the best deal.

Mr. Halvorson, the concept of managed care is one that somebody manages a person's care for them and they hopefully will be able to get a better deal. I do not know that they are inconsistent.

Mr. Rooney, is there anything that would prevent a person who has that savings account from using a portion of it to go to a managed care facility to have their services provided?

Mr. ROONEY. Sure. They could do that. Absolutely. One other thing I wish to remark on. On Monday of this week, I was with Dr. Paul Ellwood, who is the Nation's authority on what he calls "managed outcomes."

And I visited with him in Jackson Hole, Wyoming a couple of weeks ago. The $3,000 policy that covers everything above that, we are planning, with the counsel from Dr. Ellwood, to start measuring the outcomes on the physicians and the physician's groups that treat our policyholders.

It would be a great plus to us. We could use it in the marketplace if we could say to our customers, we know where you can go to get better outcomes when you have medical care. And there is nothing to prevent that from being integrated into this medical care savings account proposal. It would make it better, not worse.

Senator BREAUX. If that could be shown to the individual who has his medical care savings account as a good deal, there is no prohibition, I know, in my legislation, and I guess in your recommendations, that he or she should not be able to use that for a managed care facility to take care of their family needs.

Mr. ROONEY. I am sorry. You said it would not prevent them from using it?

Senator BREAUX. There is no prohibition on that.

Mr. ROONEY. That is absolutely correct.

Senator BREAUX. Let me ask. Senator Coats has a similar bill. My bill requires that the employer, under my proposal, provide a

catastrophic plan for the amount over and above the amount in his medical care savings account.

Mr. ROONEY. That is right.

Senator BREAUX. Do you see a problem with the requirement that it has to be done?

Mr. ROONEY. No.

Senator BREAUX. My proposal also has a formula for determining how much would be put into the savings account of the individual employer and it would be based on the premium differential that the employee would have from the year before when he went into this program.

In other words, if he decides to get a $3,000 deductible policy, that would be the amount that would go into the savings account.

Mr. ROONEY. That is right.

Senator BREAUX. Is that consistent with what you are recommending?

Mr. ROONEY. Absolutely. Yes, it is.

Senator BREAUX. I also say, in order to reduce the costs, that the interest built up in that $3,000 account that that person was entitled to and is carried over every year, that the interest that is built up is a taxable income to the individual. Do you have any comments on that?

Mr. ROONEY. Well, I suppose every one of us would like tax-free anything. But the important issue for the employee is the fact that the employee could spend the money and if there was a residue left, the employee got to keep it.

Well, that is the big-bucks item for the employee. In the last 20 years, there has only been 1 year when I would have spent as much as $3,000 in my family for health care. And, you know, I am not a kid anymore. So, that is the big issue for us; for most people.

Senator BREAUX. Let me ask a final point. The thing that concerns me is the report by Public Citizen and I think is consistent with the findings of the Congressional Budget Office as well, is an analysis by the firm of Lewin-ICF is that 20–24 percent of all American health care costs go for administrative costs, including the bills, et cetera, that are all involved.

How would your proposal reduce the administrative costs in the health care system in this country, in your opinion?

Mr. ROONEY. Well, first of all, we have established that only 6 out of every 100 people in most places are spending more than $3,000. So, as far as insurance claim processing, only those six people would have a claim processed by the insurance company.

Everybody else would be going to their account, and it is like an account at the bank, or it can, in fact, be an account at the bank. The processing cost on that would be infinitesimal. It will be big savings, compared with what it is today.

Senator BREAUX. No insurance forms to fill out.

Mr. ROONEY. That is right. None. And the doctors, of course, love that, as most doctors have at least one extra employee for the purpose of filling out forms. And it works on both ends. The doctor fills out the form, the insurance company reads the form. If you do not have to have the form at all, it saves on both ends.

The CHAIRMAN. Thank you.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Daschle, for any comments you might have.

Senator DASCHLE. Thank you, Mr. Chairman. I would only ask one question. It was recently reported that, at current trends, the cost to the employer by the year 2005 in providing health care to employees will exceed actual salary. That is how steep the increases are expected to be over the next 10 years.

To what degree do you think that trend will create pressure in public policy among employers, and others, to separate the current requirement of employers providing insurance to their employees? In other words, are we going to break the link at some point in the future between employment and health insurance?

Mr. ROONEY. There are various proposals out there. The Heritage proposal is to break the link. What we are proposing is to break most of the link because the employer would only buy insurance for the big claims. And the employer would give the rest of the money directly to the employee and say to the employee, spend it wisely.

When I say spend it wisely, it means the employee will ask the price up front. I am here in Washington today. If I want to take a present home for my wife, you can count on the fact that the first thing I will do is I will ask the price. People do not ask the price regarding medical care. Oftentimes there are alternative ways to get the service.

But, anyhow, the simple answer is, by the employer buying only the catastrophic and giving the rest of the money directly to the employee, it goes most of the way toward what you are talking about.

Senator DASCHLE. Are you predicting, Mr. Rooney, that at some point we are going to be looking for alternatives to our health care system that do not rely upon the employer/employee relationship?

Mr. ROONEY. Sure.

Senator DASCHLE. Mr. Halvorson?

Mr. HALVORSON. Senator, the link between the employer and the health care delivery system will have been broken long before 2005 if rates continue to go up at the levels you are talking about.

There will be a massive backlash in the next several years relative to the cost of care and we need to achieve significant reform as quickly as possible in order to bring those costs down. The reform ought to be focused on delivering the most efficient and effective care and ought to be focused on using health care dollars most wisely.

And it is very clear that, if that is done appropriately, the result will be better quality care than we are seeing today as well, because better quality care is actually less expensive than poor quality care.

Outcomes based care is less expensive than procedure-based care. What we need to do is have a massive reform in that direction, and, until that reform takes place, everything else is window-dressing.

Senator DASCHLE. So, in essence, neither of you feel that there is so much longstanding tradition and preference to the current method of employer responsibility that that alone could sustain this notion that it is going to be the employer's responsibility for the indefinite future; that the economic pressure itself on the em-

ployer will cause the political dynamics of this whole issue to turn so much so as to break that link sometime in the near future. Is that what you are telling us?

Mr. HALVORSON. There are definite advantages for employer-based health coverage. If the costs go up at the rate that we are talking about, the employers will not be able to afford to maintain that link. If the cost of health care in your example exceeds the cost of salaries, the employers will be a massive political force for change.

Senator DASCHLE. I thank you both. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Durenberger, for any comments you might have.

Senator DURENBERGER. Just a couple of questions of each witness.

George Halvorson, I think you just hit the nail on the head. And I thank Tom for that question, because the crucial issue here is if he is right then the tough thing that is being illustrated here—and I admire the insight of the Chairman and the staff of putting this particular panel together—is whether our business is going to be to reform the way health care is delivered in this country, or are we going just going to continue to change the way it is paid for?

I think what I heard Mr. Halvorson say is our reform focus better be on getting better care for less money, or we aren't going to make it. Just changing the way people buy into the system, this is what we have been doing for the last 10–12 years around here with DRG's, RBRVS's and things like that, and we are not making it.

My first question is about Bob Packwood's question to you about Southern California Edison and the managed care savings dwindling. My experience in Minnesota has been—and I will say your company might be different from some of the others—is that you have to distinguish between static managed care savings and dynamic managed care savings.

You have to distinguish what the economists call static savings, which is the one-time deal. If you can cut the charge for a particular service, you get a one-time savings, but it does not last. If, in fact, you can change the way that doctor practices medicine in some way and prescribes services and so forth, then you have got more of a dynamic change that is going to be ongoing.

Is it fair to say that it is really important for us to be able to distinguish between those two kinds of managed care services?

Mr. HALVORSON. I would say I agree with you totally. The major issue that we face, again, is the incentives. The incentives of the system need to be aligned with the public policy incentives of the country and the b[illegible]er.

A very quick example of how incentives can be very perverse relates to VBACS (Vaginal Birth After C-Section). Everybody in medicine knows that 60 percent of women who have had a prior C-section should have a subsequent birth normally. And the fee-for-service system over-rewards repeat C-sections.

So, instead of a 60 percent number nationally, we have about an 8-percent number. Instead of 60 percent, we have about 8. That is a terrible waste of money; it is a terrible burden to the women who are going through unnecessary major abdominal surgery; it is not

good health care for the children; and it is initially where there is a lot of medical controversy. But we do not pay for a healthy outcome. What we pay for, instead, is a given procedure.

So, what we are seeing is far too many C-sections, far too much money being wasted on lower-quality care. We can improve both of those by paying for healthy outcome.

If you have a managed care system whose inherent structure continues to be fee-for-service, and if the employers, in particular, and the buyers insist on scorekeeping on a fee-for-service basis, then we have an inherent, ongoing problem.

We need to change those incentives. And there are multiple cases. There are cases in heart surgery; there are cases in diabetes treatment; there are cases in avoiding pre-term birth. We, in our plan, have reduced pre-term birth by 47 percent lower than the State average.

The things that we do to bring down pre-term birth are not rewarded by the fee-for-service system. We could not even bill for them under typical fee-for-service procedures. So, if we were in a fee-for-service environment, we would be underpaid for doing the right thing and overpaid for doing the wrong thing.

Senator DURENBERGER. So, in effect, what we are dealing with here is whether or not we are going to manage the existing fee-for-service system——

Mr. HALVORSON. Yes. right.

Senator DURENBERGER. Or are we going to start managing the outcomes of the delivery system?

Mr. HALVORSON. Exactly.

Senator DURENBERGER. Because Mr. Rooney's proposal does not try to take us into that, one of the apparent shortcomings in the large deductible is that it presumes, as my colleague when he was testifying presumed, that somehow at that level we are going to continue as customers to buy these discreet services—these 9,000 different doctor services and these 468 hospital services, and Lord knows what else.

While this is a good idea that people ought to get more involved, the idea is that the deductible maintains the current fee-for-service system and presumes that you and I are knowledgeable buyers of those services.

I have got a couple of questions, Pat, that I have not been asked you before, and maybe you can respond for the record, because it would be helpful. There are many things that I want to do on the record to compliment you on this proposal—on catastrophic coverage, the stop-loss, those kinds of features. We are really dealing with this deductible area.

One, you said there was going to be a lot of administrative savings. But if people are buying discreet sets of services, somebody has to decide which of those services qualify for the deduction and which do not qualify for the deduction. That sounds to me like a fair amount of paper work.

Second, unless you mandate or John mandates in his bill some kind of a pass-through of the savings to the employees rather than letting the savings stay with the employer, I think we are creating some potential problems.

Third, maybe you can speak to the issue of Medigap. Our experience here is that when we put up a relatively small deductible for the elderly, they rush out and buy Medigap to cover the deductible.

What evidence is there that, when you put up $2,500 or $3,000 deductible that employees, typical Americans, are not going to rush out and do the same thing and try to cover themselves for the deductible with an insurance plan? In other words, using the tax-preferred dollars to buy into a system that you are trying to avoid?

Mr. ROONEY. First of all, the deductible has been eliminated because the employee has that much money in their savings account. Now, why waste that money on buying insurance from us? They can pay for it. They are not at risk for big dollars.

If they pay for the first $3,000 of medical care and if they only spend $1,500, the balance they have they can save. Senator Breaux's legislation does provide that that would roll over into the savings account. So, help me. I have lost track of your other questions.

Senator DURENBERGER. Well, I won't belabor the point. It would be helpful, I think, for the record, if you would take these questions and respond.

Mr. ROONEY. I am sorry. I have lost track of the first one.

The CHAIRMAN. Go ahead. We will do it.

Senator DURENBERGER. Well, it was on Medigap. I asked the question about Medigap. On the first one, why do you not just respond for the record? That is the requirement that the savings be passed through the employees rather than stay where they are.

Mr. ROONEY. It does provide that the saving pass through to the employee. That is my reading of the law. That is the way it is already.

The CHAIRMAN. All right. Thank you.

Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Just a couple of quick questions of Mr. Halvorson. First, I was fascinated by your testimony on page 6 where you show that the HMO's devoted 9.4 percent of their total 1989 expenditures to administrative cost, and the larger ones got it down to 2.5 percent.

That is as low as anybody can get them, I assume. That is a very, very encouraging figure. As has been pointed out here, we hear figures casually tossed about that the administrative costs of the American health care system account for anywhere from 20–30 percent of total cost. So, those figures are encouraging.

Secondly, and just a brief, quick answer. I am sorry, I missed your testimony. You may have touched on this. Do you find that there is a prevalence of anti-managed care laws in the States; that the legislation we have preempts those?

Mr. HALVORSON. We are seeing an increased trend in various States, largely pushed by insurance companies and individual physicians who are not very eager to be measured relative to their outcomes for anti-managed care legislation. There are quite a few bills being introduced around the country that give us some cause for concern.

Senator CHAFEE. And normally these laws say what, you cannot have a restricted list?

Mr. HALVORSON. There are a number of issues. One of them is you cannot work with the restricted list; you cannot create standards of membership; that a given provider has to be reviewed by basically peers of his or her choice. There are a number of kind of professional protection types of things.

Senator CHAFEE. Are there anti-trust problems that you run into when you have those lists?

Mr. HALVORSON. Are there anti-trust problems? Excuse me. I do not understand the question.

Senator CHAFEE. Do you encounter anti-trust problems, should you come up with a restrictive list?

Mr. HALVORSON. It is possible to do that in a way that creates anti-trust problems. It is not usually a problem.

Senator CHAFEE. All right. Now, one of the shots that is taken against managed care is—and this touches a little bit on Senator Durenberger's question—that it only produces a one-time savings—that is, a person goes into managed care, they realize a savings, but, then, from that lower base, the rate of increase is commensurate with the increases that take place with the fee-for-service system. What is your answer to that?

Mr. HALVORSON. My answer to that is that we have just begun to achieve the savings that are possible through appropriately managed care. The application of CQI, Continuous Quality Improvement techniques, the deeming processes to medicine are in their embryonic stages.

Every single project that I have seen so far has had very positive results, and those results come from looking at health care as a system and looking at populations in improving health and not just delivering individual incidence of care.

And the results of those projects, I think, is going to have a massive positive impact on both health care quality and health care efficiency in the future. And those are only possible through——

Senator CHAFEE. But so far, the HMO's and the managed care people are finding that their costs are going up about at the same rate as the fee for service?

Mr. HALVORSON. Actually, in our market that is not true. In our market, once you reach critical mass with managed care, once you have enough managed care providers so managed care sets the agenda rather than having fee-for-service set the agenda and the policies, then we can get much more control.

In our marketplace we have closed down 10, 400-bed hospitals in the last 10 years by reducing the amount of hospital days we used.

Senator CHAFEE. A final quick question. We all believe if we conduct our lifestyles in a better fashion we will be healthier: no smoking, use seat belts, et cetera.

Senator CHAFEE. I notice some insurance companies advertise for non-smokers only, for example. Does it work out that way, that those who seem to have the healthier lifestyle, indeed, do have lower medical costs? We all think it is true, but do you find it actuarily so, Mr. Rooney? Is there any way you can trace that?

Mr. ROONEY. Well, there are a number of things. One of the problems, of course, is tracing it and getting valid information. But, yes, we believe that lifestyle makes an immense amount of difference.

One of the problems, incidentally, is the present insurance system fairly well redeems the people from the consequences of their own bad decisions.

I mean, if my insurance picks up at $250 and if I am diabetic and I fail to maintain proper control of my insulin balance, well, when things go wrong, the insurance company pays for it. I am not financially at risk in any significant way.

Barbara Lutzenheizer, past President of the Society of Actuaries, says about the medical care savings account idea, that if the people had more financially at stake for themselves they would do a better job of doing the proper preventive thing in a number of ailments where it makes a big difference. Preventive care makes a big difference.

Senator CHAFEE. All right. Thank you, Mr. Chairman. Thank you both.

The CHAIRMAN. Gentlemen, thank you very much. It has been very interesting testimony. Thank you. It has been good to have you.

Mr. ROONEY. Thank you.

Mr. HALVORSON. Thank you.

The CHAIRMAN. We, next, have a panel of distinguished House Members who have taken a great deal of interest in this issue and we are looking forward to their presentation.

Congressman Charles Stenholm; Congressman Michael Andrews; Congressman Jim Cooper, from Tennessee. I want to particularly welcome my friends and my colleagues from Texas. We are delighted to have you. Congressman Stenholm, would you proceed?

STATEMENT OF HON. CHARLES W. STENHOLM, A U.S. REPRESENTATIVE FROM TEXAS

Representative STENHOLM. Mr. Chairman, it is always a pleasure to testify before your committee, and I appreciate this opportunity of coming here today, along with my colleagues, Jim Cooper and Mike Andrews, to discuss with you the health reform proposal that we will soon introduce on behalf of the Conservative Democratic Forum.

Of course, I always personally consider it a great opportunity to participate in any endeavor with the senior Senator from my State.

I have always said that, in many ways, our health care system is the best in the world. Why else would the wealthy of other lands travel here for difficult surgery; why else would the rest of the world look to us to develop the technologies which will defeat those diseases which have plagued humanity for centuries; why else would we have an ever-increasing population of octogenarians and those even older in their nineties living fulfilling lives?

But there are other ways that our health care system does not work. The message has been delivered loud and clear to Members of Congress that our health system is broke, and, as usual, Members of Congress have a great desire to have the government fix it.

Last fall, a number of members of the Conservative Democratic Forum, a group of 60 moderate and conservative Democrats within the House of Representatives, began discussing the void we felt existed in the health care reform debate occurring in Congress.

We agreed that improvements needed to be made in the affordability and the accessibility of health insurance for Americans. But we were not convinced that it was necessary to destroy our private enterprise system of insurance and health delivery, nor is it necessary to put thousands of Americans out of work by burdening their small business employers to the point that they were forced out of business.

We felt that the majority of House Democrats, not to mention American consumers, were looking for a plan that was significant enough to actually make real changes in our health delivery system, but not one that wrought the wholesale enormously costly changes which were commonly being discussed with national health care, or play-or-pay models.

It reminded me of that time of a story of a young mother that came into her newly-carpeted living room and found her five young children huddled excitedly in the room.

She walked over and was horrified to find that there were five baby skunks that her children had found there. And she said at the top of her lungs, children, run, which they promptly did, each picking up a skunk and running to a different portion of the room.

It seemed the American public had been hollering to we, in the Congress, to run, act, do something. But what we felt some of our health care leaders did was grab a skunk and run to different parts of the room. [Laughter.]

Some grabbed the nationalized health care insurance skunk; some grabbed the play-or-pay skunk; and some grabbed new and different skunks. And we kind of thought we could come up with a better skunk. [Laughter.]

It was then that we appointed a CDF Health Reform Task Force, and in May made our first public announcement of the ideas that we are submitting for consideration by the Congress in the health care to you this morning, Mr. Chairman and members of the committee.

Some of the ideas of our plan came from a variety of other bills seeking to improve our health system. For example, we borrow heavily from your insurance reform, Mr. Chairman.

Other parts of our proposal include innovative new ways to deal with access and cost of health care. One thing that quickly became clear to us in the CDF was that everyone must be asked to share in the responsibility of solving the problem.

The Federal Government must increase funding for Medicaid, community and migrant health centers, and things like childhood immunizations and other preventative care.

Hospitals and doctors must do much more in the areas of disclosing costs and outcome information; following proven strategies for health delivery and giving consumers the opportunity to make better choices.

Insurance companies must reform their exclusive policies and make uniform their claims forms. Individuals must accept a greater responsibility for their own state of health through preventative care and in paying at least a minimum amount for all care.

But, in addition to the new responsibilities of our plan, there are also some goodies for everyone. For hospitals, there is an effort to deal with the anti-trust laws that prevent cooperative agreements

among hospitals if those agreements can maintain consumer choice and reduce cost.

For both hospitals and doctors, there is a long-overdue malpractice reform; for senior citizens, there is new Medicare coverage for things such as mammograms, certain cancer screening; and, for children, there are immunizations.

To try to capsulize, our proposal seeks to create a market where consumers can shop for health care based on cost and quality like any other consumer product.

We want consumers to have all the information that will help them make the best health care decisions possible and will encourage them to make those decisions while they are healthy, not when they are sick and in a bad position to be wise consumers.

One of the central philosophies of the Conservative Democratic Forum is fiscal responsibility. That means that when this bill is introduced within a few weeks, we will have agreed upon financing for our bill.

We believe that this proposal fills a significant void in the health care debate and we will be working towards these principles of cost containment and accessibility as we debate health reform for this Nation.

Of course, at this point, it is anyone's guess as to whether we will be able to have a comprehensive health care reform signed into law this year.

Even if all we do, though, is pass smaller pieces of the pie, we want to make sure that we are part of that process, trying to help determine whether that pie will be cherry, chocolate, or coconut creme.

We thank you for your attention to our ideas. At this time, I would like to turn to Jim Cooper, the Chairman of our CDF Health Task Force. Both Jim and Mike have done a superb job in putting together the specifics of our bill and will be able to provide you with some additional details at this time.

[The prepared statement of Representative Stenholm appears in the appendix.]

The CHAIRMAN. Thank you. Congressman Cooper, if you would proceed.

STATEMENT OF HON. JIM COOPER, A U.S. REPRESENTATIVE FROM TENNESSEE

Representative COOPER. Thank you, Senator, and members of this distinguished committee. My job is to describe why our skunk is odorless. I am going to focus on the market mechanism that makes our plan so effective at cost containment.

We fundamentally change our Nation's current fee-for-service system and third-party payment system. We do it not only to achieve the static savings that have been described here today, but also the dynamic savings.

As Mr. Halvorson, the preceding witness said, we need to change the macro-environment, and that is what our plan does. We have drawn heavily on the work of Mr. Enthoven and Mr. Ellwood of the Jackson Hole group; also, a not-for-profit hospital chain called American Health Care Systems.

We have drawn heavily on the work of many of the members of this committee, as well as Senators Kassebaum and Bingaman. We have a coalition that we think is forming to, perhaps, even achieve a majority of House support; a near impossible task on these issues.

We would like, first, to set up large purchasing groups and also large provider groups. And I will describe the mechanism that we will be using. First, we need a federally-defined basic benefits package for health care needs of the average American family in the average year.

We would like an SEC-type board to get into the specifics of this package, but it is very important that there be no first-dollar coverage so that there is no free lunch, no free health care, either, and people shop according to price.

And once Americans have had an opportunity to compare apples with apples, knowing that either plan is a basic health care package providing the same benefits, they are going to become very price sensitive.

We would want to preempt the various State mandates which have unnecessarily differentiated insurance packages and driven up the cost of insurance.

Services beyond those in the basic health care package would still be available, but they would be purchased without tax subsidy. They would be purchased with the taxpayer's own money, not his neighbor's money.

We would like to pass this sort of basic health care package on the floor of the House, at least, with a base closing type mechanism, such as the mechanism we use to close certain military bases in our country.

We would like to require employers not to pay for health care benefits for all employees—we are not for pay-or-play—but we would like to require employers to provide a simple menu of choices to all their employees and to provide those employees with a simple payroll tax deduction so it would be easy for the employees in companies where the employer did not pick up the whole cost to pay for the cost of these plans themselves.

We would like to provide government help to employers in providing this simple menu so that employers are not overburdened with a lot of paper work, and we have a mechanism for doing that so that these simple menus could be offered nationally.

Once employees are able to choose between different basic health care plans, they will be very price-sensitive, indeed, and the lowest cost plan will end up with most of the business, which we think is a very important outcome.

Again, enhanced benefits, add-ons above basic care, would still be available like they are under Medigap today, but using the taxpayer's own money, not their neighbor's money.

We would like to preserve the current tax benefits that are available for basic health care plans, but we would like to limit—and I am going to be very specific in the way I describe this—the employer's tax deductibility.

As the committee is well aware, there are two primary tax benefits available today. One, is the exclusion to the employee; a largely

invisible but very valuable tax benefit for the employee. We would keep that completely intact. We would not touch that at all.

But there is a second benefit. It is the employer's deduction. We would like to limit that to the cost of the basic health care plan in the area. Deluxe plans would no longer qualify for full tax deductibility.

They would only qualify to the extent that they include that basic care element. So, to the extent you want an add-on, an enhanced benefit, you would have to pay for that with your own money.

That small change right there saves a great deal of money—$10 billion a year—money which we would like to use to expand access to health care in our system, and we have other financing mechanisms, such as changing the Medicare disproportionate share program, and other things.

But it is not only important for the revenue it raises, it is also vitally important because it forces shopping for the first time for low-cost, quality health care plans and it would also discourage the offering of some of these first-dollar health benefit plans that certain fortunate corporate CEO's have been able to get unlimited tax subsidies for purchasing.

We would like to establish large purchasing groups so that our small business, as the Chairman well is aware and has helped in his plan a great deal, to allow them economies of scale and purchasing, to allow them risk-spreading, to allow them group rates so that we can cut into sometimes administrative charges that are as high as 40 percent.

We need to lower these administrative costs so that small businessmen are, in fact, buying insurance, not buying into expense insurance company overhead. Well, that is on the purchasing side.

On the provider side, our changes are equally fundamental. We would like to set up accountable health partnerships, groups which could be led by insurance companies, by hospitals, by doctors, by entrepreneurs, or any other health care providers, but groups which would do several things: have extensive outcomes reporting so that consumers would know what they were buying, so they would know the mortality rates and other important statistics.

And these would be reported on a fair, population-based method so that you would not be discriminated against if you were a geriatric practitioner versus a pediatric practitioner.

We would also pre-qualify these partnerships so they would be able to provide the care to the people who needed it. And these could be HMO's, staff model, or otherwise; they could be PPO's, IPA's; the key thing is they have to be efficient. Efficient. We do not want to pre-judge the delivery mechanism, although my personal guess is that staff model type HMO's would win out.

These groups would have to take all-comers. They would have to be responsible for a representative slice of the American population. They could not cream-skim; they could not search for the young, healthy and wealthy 20-year-olds that so many of our insurance companies today want to have.

They would have to compete on the basis of providing quality health care to a fair slice of the American public instead of shedding risks, instead of getting rid of older, unhealthy Americans.

Another very important change is we would like to bundle health insurance and health care as a single product. No longer would consumers be buying the promise of an insurance company that would pay some provider some money.

You would be bargaining with that health care provider/ insurance company for health care for the coming year, much as is available today for the Federal employee in the current Federal Employee Health Benefit system; a system that, by the way, is even praised by the Heritage Foundation for its progress in helping average Americans shop in a more intelligent fashion for health care.

These are very important changes. They would change the system, as Mr. Durenberger and others were pointing out in their comments. Not just shift who pays for it, but change the fundamentals in a way that will give us real cost containment by setting up these large purchasing and provider groups, having tough negotiations between them, having a low-bid system.

Guess what? Prices can go down, not just up. There are many areas of our country which have been traditionally and unnecessarily high-cost areas. We can cut out the waste in those areas with this efficient market mechanism. I appreciate the indulgence of the Chair in explaining why we have, we think, the odorless skunk.

The CHAIRMAN. Interesting presentation. Congressman Andrews.

STATEMENT OF HON. MICHAEL A. ANDREWS, A U.S. REPRESENTATIVE FROM TEXAS

Representative ANDREWS. Thank you very much, Mr. Chairman. And, if I could, I would just like to add a few points to what Jim has tried to enumerate.

We have a system today, when all of us go to get health care insurance, if you think about it, when you go to shop for insurance you always ask about cost.

Senator Breaux used the example of his two children and the deductibles, and that is a problem that all Americans face every time they try to buy insurance, is the increased cost.

When you get sick, or you go to get health care, most Americans never ask about cost. What I think is not particularly compelling about the proposal of Mr. Rooney is that I really honestly think if my child gets sick, if my wife or my mother gets ill, or I get sick, I do not care about the cost.

That is one of the last things that I am concerned about, and I am certainly not going to make a decision on the health care of my child based on saving money in some fund.

And that is part of the problem, because we have a system that rewards inefficiency that multiplies the cost.

And what we have tried to do is bond these two parts of health care together—the insurer and the delivery system—where we, as consumers, shop once a year, almost like you buy a car, with a lot more information about how good a doctor is, how efficient a hospital is.

Competition between these different large partnership groups, we think, would be intense, primarily because the least costly partnership group in a region would set the ceiling on the cost.

That is where we get, we think, the $10 billion, because we are going to save money because no one gets rewarded if they want to spend more than the least expensive plan.

We think we are onto something here. Politically, I would suggest to the committee that I do not think any other plan can pass the House. I do not think we can change policy by going to a Canadian system, or any other proposal that some of my Democratic colleagues have called for, or some of the plans that are presently being considered in the House by the Republican side.

Representative Stenholm is absolutely right: we have got to pay for the system. And that is one question that all of us have to ask every proponent. We raise $10 billion by putting in a ceiling.

We think there is going to be additional cost as well, and I think we have got to be honest about paying for it. Raising tobacco taxes is one way I think we should look down the road to offset some of the health costs that are involved in our system.

But we have to deal with the cost problem and I think that our program, our proposal, more than any other that is being debated in the House right now, tries to get to that cost issue.

[The prepared statement of Representative Andrews appears in the appendix.]

The CHAIRMAN. Thank you. Congressman Cooper, now, you talked about removing the deductibility to the employer above the basic package, retaining the exclusion for the employee. Now, suppose they go above the basic package, what about the exclusion for the employee? You would obviously preserve it for the basic package. How about if we give ourselves a more generous plan?

Representative COOPER. We would observe the exclusion as it is today, completely intact, so that if the employee chose a deluxe plan, the employer would not get the full tax deduction, but the employee would still have all of that excluded from the employee's income.

The CHAIRMAN. All right. What do you do about the availability? I have listened to Alain Enthoven and I thought he had some very good suggestions. But one of the things that concerns me is the question of the availability of HMO's for rural areas. What do you do about that?

Representative COOPER. Many rural areas would not non-market areas. We would have to acknowledge that because there is a doctor shortage today; there is likely to be a doctor and health care provider shortage in the future.

That is why, as Congressman Stenholm stressed, we would have to push community health clinics a great deal, the national health service corps, and other proven Federal programs to get more health care out where it is needed in rural areas.

We would also have to acknowledge that market sort of price setting might not work in a rural area, since there is a physician and health care provider shortage.

So, Dr. Enthoven and we recognize that in rural areas and other underserved areas, we need to acknowledge the shortages and have government mechanisms to fulfill the needs in those areas. In the vast majority of the country, markets can work and should be allowed to work.

I should add—and we have not stressed it adequately today—we would completely transform the current Medicaid program. Today, Medicaid serves less than half of the population under poverty.

We would cover everyone under a 100 percent Federal program up to 100 percent of poverty. And from 100–200 percent of poverty we would have a buy-in system on a sliding scale so you would be heavily subsidized in your purchase of Medicaid.

And that will go a long way toward covering virtually all of the uncovered today who are not employed. And we feel that really four-fold expansion of Medicaid would go a long way toward providing perhaps not perfect universal access, but 95–98 percent universal access to insurance.

The CHAIRMAN. CBO Director Reischauer, when he was testifying, was alleging some uncertainty in the cost containment approach of this and was talking about a global budget cap on national health spending, and then that the HMO's operate under that kind of constraint. What is your reaction to that?

Representative COOPER. Recent talks with CBO have indicated they are more willing to score savings from a market mechanism. It is true they have traditionally relied on global budgeting caps as a crutch to help them score. We just want to make sure that the global budgeting cap does not undermine our market mechanism.

So often, as Mr. Halvorson and other witnesses have testified, if you have a global budget cap, HMO's and other efficient providers are not required to be as efficient as they can. They will come right under your cap when they could be providing service just as good down here at a lower price level.

We want to make sure that any sort of cap that this committee may consider does not involve the sort of shadow pricing that you lose much of the efficiency of your system.

Fee-for-service, alone, is a very inefficient and costly mechanism that we have relied on for a long time that has encouraged a great deal of shadow pricing. And, as you heard from the earlier panel, it is one of the primary reasons HMO savings are not as great as they could have been.

So, if you consider a global budget cap, please do not let it interfere with the market mechanism, which is a very delicate mechanism, which will be ruined if you have a bureaucratically set fee, arbitrarily set cap limit, that will enable them to come right under and reap all sorts of profits they are really not entitled to when they can provide service a lot cheaper.

A good example is in California this last year. Governor Wilson had a terrible budget problem. He had to limit the State contribution in employee health care plans to $150 a month. People were saying it could not be done.

Well, all of a sudden, five HMO's were able to come in well under $150. They had never been pushed that hard before, but they were able to do it.

The CHAIRMAN. But you are saying they came in well under the $150, and did not come in just under the cap. Now, why is there not still some competition?

Representative COOPER. Well, perhaps if Governor Wilson had been limiting the contribution to $100, they could have come in under $100. We do not really know the full extent of the savings

unless the market is really allowed to operate. Whatever number you pick, whether it is $150, or $200, or $100, the HMO's will probably come in $5 cheaper.

The CHAIRMAN. Yes. But you just told me they came in substantially under the $150.

Representative COOPER. But we do not know, if an even lower had been produced, they could have come in under that. These groups need to be pushed to the limit. They can perform if we force them to perform. But an arbitrary cap will encourage shadow pricing, which will enable them to come in right under.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. I want to welcome my three colleagues and commend them for the thought and the work that they have put into this proposal. It certainly has a substantial degree of merit, and I applaud them for proposing it.

I know them to be not only three excellent policymakers; people whose careers I have watched for a long time, but they are also three good politicians. And I want to ask them about the politics of this thing that is intriguing to me personally. I have talked about this before in other meetings.

Veterans have a government-sponsored program that they will fight for and go to the mat for if they have to. The military has a government-sponsored program that they will fight for and go to the mat for; Indians; seniors; all with government-sponsored programs which will defend, protect, and argue for to whatever degree necessary to protect their interests.

You mentioned the politics of all this. What I am curious about, if you could enlighten us, given your perspective, what is it that is unique in politics and everything else, that argues for a completely different system?

Representative COOPER. If I may respond.

Senator DASCHLE. Yes.

Representative COOPER. I think trust in government today is at an all-time low. People are afraid of government rationing of health care; of long lines; of bureaucratically arbitrary determinations of which hospital or what State is going to get what health care.

Senator DASCHLE. But, then why, Jim, would you not see all of these groups coming forward saying, get rid of it; I do not want what I have got. This is ridiculous. I cannot stand it. I want to get into that private sector which is more efficient, where we do not have lines, and where there is no rationing.

Representative COOPER. I do not know about the gentlemen, but all I hear from my veterans is how inadequate the VA hospital system is; how they are afraid it is second-rate care; how most veterans who can afford it do not go to VA hospitals.

It is true they will fight to defend the system, but they want it dramatically improved. They are mad at the second-class care that is oftentimes offered today.

The biggest response I get in my speeches is when I steal Connie Horner's line and say, if you like the compassion of the IRS, the efficiency of the Postal Service, and Pentagon prices, you will love the government-sponsored health care system.

Representative ANDREWS. I think most polls show right now, Senator, something like 70 percent of the American people are for

radical change—not just change, but radical change—in our health care system.

As, I think, one of the earlier witnesses testified, by the first part of the next century we will be spending about one-third of our tax dollar every year on health care costs if we do not make some dramatic changes.

There are special interest groups out there, from senior citizens groups, to labor union groups, business groups, that do not want changes in the system. And I agree: it is going to be very, very hard politically to make the kind of dramatic change we are going to have to make.

Things around the margin are not going to change the problems we have with costs that continue to go up. And if we want to have a system which rewards inefficiency, which we have now, that drives those costs up, then we should just deal with the margins. But if we want to make some fundamental changes, we are going to upset a lot of special interest groups to get there.

Senator DASCHLE. But, do you see the paradox? On the one hand, you have Americans, who, I am told, constitute about 40 percent of our constituency out there that are under government-sponsored programs fighting for the status quo, recognizing the shortcomings, arguing that there ought to be more, but certainly defending the program under which they now receive care.

Then, on the other hand, you have got 60 percent of the people outside of the program saying, we do not want that, or at least presumably saying that. How is it that those who are under the program fight for it; those who are not in the program claim to argue against it?

Representative ANDREWS. Well, one of the biggest proponents for catastrophic health insurance was AARP. Most Americans wanted the benefits; very few Americans wanted to pay the premiums for those benefits.

It is one thing to propose additional benefits or want more out of a system which drives costs even higher; it is something else to pay for it. And that, as I said earlier, what I think is the hardest question of all. We have got to pay for the program.

Senator DASCHLE. But are we paying more or paying in a different form? That is the real question. Are we actually paying more?

Representative STENHOLM. If I might interject there. I think that is the fundamental question that we are all getting to. And when you mentioned the special interest groups, et cetera. the idea of competition examination based on the merit is something we propose for all groups. We cannot do this in a vacuum. It has to be done——

Senator DASCHLE. So, you would abolish the Veteran's Administration.

Representative STENHOLM. No. I say we do not come to that conclusion at this point. But I think, as I now serve on the Budget Committee, and right now, this afternoon, will be the third meeting looking at what we can do to get our fiscal house in order.

You immediately come to the question of budget fiscal matters and health care costs. And immediately we have the Veteran's

Committee coming to us on the Budget Committee making suggestions of needed improvements that cost money.

And, therefore, as we look at how we are going to increase the cost and provide accessibility, I think this is the kind of debate that we have to get into.

And I think if this concept is good, we will see our veterans coming forward and proposing changes to adapt to it. If it is not, I think we will have just the opposite. But we do not know that today, and this is why we propose this as something to be looked at and answered.

Senator DASCHLE. I am out of time. I thank you again, and commend you.

The CHAIRMAN. Senator Durenberger, for any comments you might make.

Senator DURENBERGER. I would like to begin with a comment. This is pretty exciting. I am really pleased to see the three of you here, and I am pleased to see your leadership on the House side and on the Senate side. I think you are right on.

I mean, I think everything you have done in terms of both your goals, your objectives and your means to achieve them, I think, are going to provide everybody with a vision of where we ought to go. The realities of how quickly it gets done, and some of those sort of issues, are something we can debate at another time.

As I understand the proposal, it meets one of the first tests that any politician ought to meet, and that is a national goal of equal access to superior quality health care through a system of universal coverage of financial risk.

The second thing that I observe about it is that it deals with the realities that you cannot get there from here unless you contain costs, and that that cost containment is not going to get done by a government agency, or DRG's, or RBRVS's, or some other mucking around with the fee-for-service system that we currently have, as we have all been doing over the last 10–12 years.

It also seems to deal with the reality that we are not going to make it unless we deal with the inequities in the financing in this system.

The tax subsidies are inequitable; the access in the social insurance system is inequitable; it is clear that access through work in this country is totally inequitable if we are saying people get treated differently depending on where they work.

The mechanisms that I understand you are using to get at cost containment, if I had to choose one word, I would call it productivity—making the whole system work better by having everybody in the system do what they do best.

You start with the health plan because we, who used to be good buyers of health care in this very complicated system, no longer can buy discreet services. But one thing we can do is buy a good health plan.

The problem with being able to buy a good health plan today is we have got 1,500 people out there masquerading as good health plans and competing against a George Halvorson and a handful of other good health plans at the premiums level, rather than at the services level. Would you agree with that?

Representative STENHOLM. Absolutely.

Representative COOPER. Yes.

Senator DURENBERGER. So, if we are going to try to get all of us up to speed on what role we play as consumers, you want to do it at the health plan level. One of the necessities, of course, in getting to that is finding some way to challenge some large number of the current health insurers or health plan folks to go back into the property and casualty business, or do something else.

One way to do that is to provide a federally-qualified health plan with a set of prescribed services that folks who are just in the property and casualty business probably are not going to want to try to sell to us.

My difficulty, in struggling with the same issues that you are, is in trying to describe what those services ought to be. I suppose the other part of the issue is how to price those services in a way that is competitive.

It is fair to say that another key in consumers "buying right" is that the services ought to be comparable. We all talk about the Federal Employees Health Benefit Plan as being the ideal employer relating to their employees.

But then we offer up 22 different kinds of plans which are priced differently, their services are described differently, and we, the Federal employees, are not very good consumers.

Could one of you address that issue a little bit? Because that keeps getting put up here as an ideal way of doing things.

Representative COOPER. Let me, first, thank the gentleman for his kind words about our proposal, and I would urge the gentleman to talk to some of his colleagues in the House and let him use his credibility to promote our plan in the House.

You are pointing out exactly two of the key problems. Defining the basic benefits package is going to be very tough. It is going to take a committee of experts to do it.

I do not really feel that the Congress is well-equipped to do that, but I think we should have an up or down vote on a package of basic health benefits. You are exactly right that we need to have a competitive pricing system so that we can get those costs down. I do not really know what the price of a basic health plan should be, but we should have several different types of providers competing to be the most efficient, and then we will know what the right price is.

That sort of competitive bidding system, once you are comparing apples with apples—and that is the key thing—you need a federally-defined basic package so that you are not able to lure a whole segment of the market with an offer of free eyeglasses, or another segment of the market with an offer of free dental care.

One of my colleagues on the Ways and Means Committee pointed out to me that he was about to switch his Federal Employee Health Benefits Plan because he is going to have some dental work done next year.

And he is, therefore, going to get a great dental plan. That is exactly the sort of adverse risk selection that should not be tolerated in any good, new health care system in this country.

The CHAIRMAN. Thank you very much. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. First, I want to commend each of the gentlemen here. I have worked with Congressman Cooper on other efforts in preventative medicine.

We are the driving force behind mandatory seat belts and motorcyclist's helmets, which has not brought me tremendous support in Rhode Island from the Motorcycle Association. [Laughter.]

I do not know how your folks are doing with you, Congressman.

Representative COOPER. I got denounced by the Tennessee State Legislature for having succeeded with you in passing the legislation nationwide.

Senator CHAFEE. Well, I can just report that we have a great big parade every year, and all of the motorcyclists gather together in one spot. And none of them wave to me with all five fingers, let me tell you that. [Laughter.]

The CHAIRMAN. I would say, Senator, I led that fight years ago and I saw a strange coalition of one of the most liberal Senators in the Senate and one of the most conservative ones. And I could hear those motorcycles running up and down the aisles in California as they ran over us on that issue.

Senator CHAFEE. As I understand what you are proposing, it is essentially the Enthoven system. And let me see if I can just briefly describe it. Your belief is that managed care does not produce substantial long-term savings when it competes with fee-for-service. They come in just below.

All they have got to do is just price themselves a little lower. And it is only when they compete with other managed care plans that we are going to see the desired result, i.e., the long-term savings. Is that your argument?

Representative COOPER. That is exactly right, Senator. And, an addition I should make is that Mr. Enthoven is for a pay-or-play type universal coverage. We do not feel that can pass the House of Representatives, so we have excluded that part of his plan from our package.

Senator CHAFEE. Now, one of the complaints about the Enthoven system is that the suggestion is unworkable in rural areas with a very diffuse population, although I think he has used the illustration of a small water district that has four people that are members of some plan he talks about. And each of you are from rural areas, I believe, so obviously you think this will take care of your folks.

Representative COOPER. Charlie Stenholm and I are from a very rural area. Mike Andrews represents Houston, Texas.

Representative STENHOLM. From Houston. A small city in Texas. [Laughter.]

Representative COOPER. My district is 100 percent rural. I have no town larger than 19,000 people. Mr. Stenholm's district, I think, is even more rural than that, perhaps.

Senator CHAFEE. And, obviously, you believe that your plan takes care of rural folks successfully.

Representative COOPER. And I have gotten an excellent response from health care practitioners in my rural area.

Senator CHAFEE. Now, the administration set forth the package, and then it is sent up here and can only be rejected. Is that the way it works when you are comparing it to the base closure?

Representative COOPER. Well, I would not call it an administration package. We would like to set up an SEC-type health care board for our country and have them study what should be included in a basic health care package.

And then at least the House would have one up or down vote on what is in that package. If we start each adding our own favorite health care service, we will soon no longer have a basic health care package. It will be the most extravagant health care package ever devised.

Senator CHAFEE. Well, that worries me, too. And we all know what has happened in the mandated benefits in the various States, and I am afraid if we are not careful we are liable to get the same thing up here.

Now, as I understand your proposal, anything above the basic package would not be deductible by the employer, and the employee would have to pay for it with after-tax dollars; it would not be deductible by the employee.

Representative COOPER. Exactly right. One add on is we would like to, as many folks would like to, for the self-employed individual, raise deductibility up to the appropriate 100 percent level.

But if you pay your own premium for your health insurance, you would only be able to get that deduction for your basic health care package. Even the self-employed would have to pay for the deluxe add-ons with after-tax dollars.

Senator CHAFEE. So, the self-employed would be able to deduct 100 percent of the cost of the basic package.

Representative COOPER. Exactly. And that is a long overdue change in our tax system.

Senator CHAFEE. Well, we have been struggling with that here, too. We have been trying to get money for it. That is the only difficulty, or else we would certainly go a lot further than we have.

Now, you heard Mr. Halvorson with his citing the statistics in the fee-for-service that comes up with the Caesarean sections. You are confident that that would not occur under your managed care proposal?

Representative COOPER. Absolutely right. Because no longer would fee-for-service be rewarded; no longer would these unnecessary C-sections be rewarded.

The gentleman probably knows that if we have the same percentage of C-sections today in America as we had in 1980, we could save $1 billion a year just right there. But, because of the fee-for-service/fee-for-procedure payment system, so many unnecessary procedures are being done in America today.

Senator CHAFEE. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I want to be complimentary, as Senator Durenberger was, about your efforts. I am not sure, at this point, that I can disagree with your solution, but I know that solutions are very complicated and we had better not reach a judgment too hastily on some of them.

I helped work on the task force that Senator Chafee had put together, and I am a co-sponsor of that bill. That will give you a rough idea where my starting position is. I just have one question,

and that is, how would your approach affect existing health care plans for Federal employees and members of Congress?

And I do not ask that because I think that we have the ideal program, or I do not want to affect our program. I just want to know how your proposal would interact with that.

Representative COOPER. The Federal Employees Health Benefits is a darn good system now, but it could and should be improved in the ways we have described for all of America.

And I would like to toss out to this committee the idea that if we need to act this year, perhaps going ahead and reforming Federal Employee Health Benefits is something we could and should do this year to make that system work even better than it does today by defining a uniform, basic benefits package and by changing deductibility.

That would be a 9-million-person experiment, and, for the first time, instead of Congress exempting itself and Federal employees from laws we pass for the rest of the Nation, we would be leading the way by using ourselves as guinea pigs, trying it out on ourselves first. And I think that would be a very important and beneficial change in usual Congressional procedure.

Senator GRASSLEY. So, then, your program does not in any way exclude and exempt Federal employees and Congress from its benefits.

Representative COOPER. Absolutely not. In fact, what it really does is try to share some of the benefits that Federal employees that have been enjoying for some time now with the rest of the American public.

Senator GRASSLEY. Well, I think you need to be complimented on that point, not only because it sets a good example for other areas of law that Congress has exempted itself from that we should not be exempt from, but also because there are benefits that need to be made available more widely. And what is good for the rest of the country ought to be good for us in Congress.

Secondly, some of the programs that are highly focused here do exempt Congress and Federal employees. And I think that ought to immediately send a signal to the public at large that if it is not good enough for Congress or the Federal employees, then, is it really very good for the country at large?

Representative COOPER. I agree completely with the gentleman.

Senator GRASSLEY. Thank you, Mr. Chairman.

Representative STENHOLM. If I might comment a little further. Another part of our plan we have not talked about a great deal today. But where there are good ideas, demonstrations, pilot projects seem to be in order, and that is what Jim was just saying in this case.

But there perhaps can be other areas that we can isolate in which someone has an idea that is worthy of trying. But before we do it on a national basis, let us try it and see if it works if we can find groups or individuals or instances where that would make sense.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. I think the testimony has been excellent. I think you have given a lot of thought to it. It is very productive.

I must say that on my Better Access to Affordable Health Care bill that passed the Senate with very substantial bipartisan support, that there is a health commission there that could serve to define the basic benefit program that you are talking about.

And I was pleased to see that you have adopted some of the preventative health care measures in addition that we have in that legislation. So, I think you have made a major contribution. We are very appreciative. Yes?

Representative STENHOLM. Mr. Chairman, one other brief comment. You asked about the rural consequences of this.

The CHAIRMAN. You and I share that concern.

Representative STENHOLM. I certainly do. My district, 32 counties, 32,000 square miles; is about as rural as you can get. We have had 11 hospitals close in the last 10 years.

I take off my Conservative Democratic Forum hat for just a moment and put on the Rural Health Care Coalition co-chairman's hat, which I share with Pat Roberts, of Kansas, and would say that 176 of us are looking very carefully at what we do in the overall health reform to make certain that we do not shoot rural America in both feet again as we have done with some of our other efforts in the past.

And I would offer this thought, and I know, Mr. Chairman, you, of all people, are very familiar with the Rural Electrification Program. I think we can learn something from that endeavor as we, in fact, determine how to provide access to health care.

One of the primary goals of rural electrification was universal coverage, to provide coverage to everyone. We have done a pretty darn good job at that, and we have done it at a competitive price, and it has worked.

I think we can borrow from that concept. In fact, we can learn from the examples. Now every rural hospital in Texas—and I suspect I speak for every State right now—has had a tremendous struggle of meeting those rules and regulations that we have passed.

But most of them are making it. And I do not know of anybody right now that is in there with us and is willing to roll up their sleeves and work with this committee and with the House and all of us in trying to find these answers. And we know that that is going to be one of the guideposts that we are going to want to use on our side.

The CHAIRMAN. Well, as you know, we have passed legislation to try to help those rural hospitals in getting the Medicare compensation up to where it is comparable with the urban areas, and we are making some headway on that. Gentlemen, thank you very much.

Senator BREAUX. Mr. Chairman.

The CHAIRMAN. Yes, Senator Breaux.

Senator BREAUX. In the interest of time, let me just make a comment and commend our colleagues for what I think is a major contribution. A lot of work, I can tell, has gone into their proposal. And I think it certainly behooves us to study it very carefully and see if it cannot be advanced in this committee. Thank you.

The CHAIRMAN. I would like to comment. Senator Durenberger is the principal co-sponsor of that particular piece of legislation to

which I was referring. He has been a very major contributor to it. Thank you, gentlemen.

Our next panel consists of Dr. Stuart Butler, the vice president and director of domestic and economic policy studies from the Heritage Foundation; Dr. Judith Feder, who is the co-director of the Center for Health Policy Studies, Georgetown University; and Dr. Kenneth Thorpe, associate professor, Department of Health Policy and Administration, University of North Carolina. Senator Breaux will act as chairman of this part of the hearing, since I have a conflict in another engagement.

Senator BREAUX. Gentleman and lady, welcome to the committee. Dr. Butler, we have you listed first, if you would like to proceed.

STATEMENT OF STUART M. BUTLER Ph.D., VICE PRESIDENT AND DIRECTOR OF DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION, WASHINGTON, DC

Dr. BUTLER. Thank you, Mr. Chairman, for the opportunity to testify on the reform of the health care system. I see these hearings as part of a national debate that is long overdue.

The American people are well aware of the symptoms of today's flawed symptoms—such as inflation and gaps in coverage—and they want action to correct them, but are uncertain about what needs to be done.

A national debate can and should crystallize the options so that the people can give Congress clearer guidance on what structural reform should be undertaken.

Mr. Chairman, I can well understand that in an area as politically sensitive as health care, Congress is hesitant to enact sweeping reform that may trigger a backlash, as the catastrophic care legislation did in 1988; thus, there is interest in enacting only modest reforms.

While some of these measures would help somewhat, only fundamental reform can create a universal system based on sound economic and political principles that will address the demands of the American people.

The national debate should center on the answers to some basic questions about the structure of a national health care system. I believe two questions are crucial. One, in a universal health system, who ultimately should decide what medical services a family can receive—the government, employers, or the family itself?

And, two, what economic mechanism is most likely to restrain costs with the highest degree of economic efficiency—government central planning with sweeping price controls, employers trying to force their employees to reduce their health care demands, or consumer choice in a competitive market?

When you strip away all of the details of the various bills and proposals, the debate really boils down to different answers to these two questions. I believe the only successful, efficient, and popular universal health system will be one that is based on the democratic principle of consumer choice and which uses the economic power of consumer choice in a competitive market to restrain costs.

Such a system does not exist today, Mr. Chairman, because the market is profoundly distorted and the consumer incentives are de-

structively perverse because of the tax treatment of health care spending.

By effectively restricting tax relief for health care spending only to plans sponsored by an employer, and doing so without limit, we created most of the problems we now are trying to solve: Families losing coverage when they lose or move their jobs; too much tax help going to the rich and too little going to the poor; employees of struggling, small firms having no coverage; employees of larger firms having no incentive to economize.

The key to creating a universal health system based on consumer choice is to reform this tax treatment. The Heritage Foundation has developed a proposal to do that.

Under the Heritage Consumer Choice Health Plan, the existing tax exclusion for company-provided health plans and other deductions for health spending will be replaced dollar-for-dollar in a budget-neutral way with a new refundable tax credit available to all working families for the purchase of health insurance or out-of-pocket medical expenses.

All families not on welfare or in the Social Security system would be required to enroll in at least a basic plan. Full details of the Heritage proposal accompanies my prepared statement, Mr. Chairman.

In addition, I have made available to you and the committee the complete analysis of the proposal by the firm of Lewin-ICF, so that members can see all the assumptions on which it is based and all the projected effects on government, businesses, and households.

In the interest of full and open debate, Mr. Chairman, I would urge you to request all other individuals and organizations presenting plans to this committee to disclose similar proprietary information.

As you will see from the material I have provided the tax reform I propose would mean lower after-tax health costs for the vast majority of Americans and significant assistance for the working poor to afford coverage.

But the proposal would have other important implications. It would create a national health system for America. All families will be under Medicare, Medicaid, or the new plan.

It would mean that Americans no longer would be dependent on their employers for subsidized access to the health system. Families could choose from among a wide array of health plans and receive the refundable tax credit. In effect, this would be like extending the Federal Employee Health Benefits Program to every family.

Significantly, the proposal would encourage organizations other than employers to act as sponsors of health care plans.

This would mean that workers could move jobs without any interruption or change in their health care plan, and that workers for small firms would have the same choice of health plans and the same degree of tax subsidy as workers in large firms.

We anticipate, too, that millions of Americans under our proposal would pick plans offered through a union, as many Federal employees do. And we believe families in rural areas might choose plans offered through a number of organizations, such as a farm bureau, or even a church-based group.

In fact, we expect groups of black churches to be an obvious sponsor of health plans in the inner city. Further, the proposal would introduce keen competition between plans, spurred by the incentive for consumers to pick the best value for money.

And I emphasize here that we are talking about consumers picking between plans to provide them with a complete range of services, not bargaining with doctors on individual prices.

This powerful dynamic would restrain costs without sacrificing efficiency. We anticipate that one result of this would be a far greater inclination among families to choose managed care plans.

I would note that Consumer Choice and the FEHBP has encouraged managed care and kept the rate of cost increase markedly below that in the private sector. Thank you, Mr. Chairman. I would be happy to answer any questions that you may have.

Senator BREAUX. Thank you, Dr. Butler.

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

Senator BREAUX. Dr. Feder.

STATEMENT OF JUDITH FEDER, Ph.D., CO-DIRECTOR, CENTER FOR HEALTH POLICY STUDIES, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Dr. FEDER. Thank you, Senator. It is a pleasure to have the opportunity to speak before you this morning on tax incentive based approaches to health care reform.

In my view, the effectiveness of any reform proposal, whether tax incentive based or otherwise, rests on its capacity to achieve two fundamental goals: health care coverage for all Americans and containment of health care costs.

These objectives, on which analysts, and, I would argue, most policymakers agree are critical not only on moral grounds to ensure universal access to health care for all Americans when they need it; they are also essential to achieve equitable and stable health care financing that neither shifts costs from one purchaser to another, nor absorbs an ever-growing share of the Nation's resources.

You have discussed a lot of tax incentive based plans this morning, and I understand you had the administration testify yesterday.

These plans differ a great deal, and I want to focus my remarks on what I would call the gap-filling approach: strategies designed to help Americans get insurance through tax credits—or sometimes other means, and to encourage competition to contain costs. That approach differs from Stuart Butler's proposal, and I will comment on his proposal if we have time.

The gap-filling approaches that we are talking about are the administration's proposal, Senator Cohen's proposal, and I think Senator Chafee's proposal falls in that category. Let me describe some of their general features and then focus in particular on the administration proposal.

In general, gap-filling tax credit proposals, while they would enhance the capacity of some Americans now lacking coverage to obtain it, have several limitations.

First, they leave too many uninsured Americans still uninsured. Rather than guarantee all Americans affordable coverage, gap-filling approaches leave insurance a catastrophic expense beyond the means of moderate income Americans.

Second, they potentially shift private to public financing of significant health care costs. Rather than target public benefits to the neediest, such approaches benefit the already privately insured and may encourage employers to reduce contributions and coverage for their employees.

Third, as currently structured, most of them fail to contain costs. Rather than guarantee participation by all purchasers in a system that assures appropriate payment for appropriate services, such approaches rely on encouraging the spread of managed care, a strategy that, by itself, perpetuates the capacity of some to shift costs to others and that has not slowed rates of increase in health care costs over the last decade.

Now, let me focus in particular on the administration's plan. That proposal would cover, at best, half the currently uninsured. Tax credits in most plans are limited to people within certain income levels.

In this plan, tax credits drop almost to zero for families with incomes at 150 percent of the poverty level, meaning that a family of three with an income of $17,000 would have to spend more than 20 percent of their income in order to obtain health care unless their employer provided coverage.

Second, the proposal would leave currently insured Americans at risk. The insurance reform proposals that are included in most broad strategies of this type can guarantee the availability but not the affordability of employer-based insurance.

The administration proposal fails to guarantee insured Americans that their employers, already struggling with insurance costs, will continue to provide them protection.

And, finally, the administration proposal would do little to contain costs. By simply extending to small employers the opportunity to pursue managed care to small employers that large employers have already found inadequate in containing their costs, they fail to do the job.

Now, turning briefly to the Heritage Foundation proposal, it is different from the administration's and the others that are encouraging coverage because it requires coverage.

But, in so doing, it undermines the risk pooling that we have got in the employer-based coverage system and, in fact, exacerbates the very problems you are trying to deal with involving excessive administrative costs and risk selection in the insurance industry by leaving individuals on their own to seek and shop for care.

In my view, Senators, universal coverage and cost containment can only be achieved when government assumes responsibility for building a health care system that guarantees all Americans affordable coverage and requires all purchasers to participate equally in a system to contain costs. Thank you.

Senator BREAUX. Perfect timing. Thank you very much, Doctor.

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

Senator BREAUX. Dr. Thorpe.

STATEMENT OF KENNETH E. THORPE, Ph.D., ASSOCIATE PROFESSOR, DEPARTMENT OF HEALTH POLICY AND ADMINISTRATION, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, NC

Dr. THORPE. Thank you, Mr. Chairman and members of the committee. Thank you for inviting me to testify and comment on tax incentive approaches to health care reform.

My comments will focus on the potential impact such programs may have based on empirical research that I and others have done evaluating similar approaches.

The centerpiece of these proposals under discussion today is the provision of tax credits and deductions to assist individuals in purchasing health insurance.

The proposals differ with respect to the target population and the extent of the subsidy. For discussion, I use a prototypical approach where individuals receive a refundable tax credit of up to $1,200 per year, and families receive one limited to $2,400 per year.

My remarks will analyze these tax incentive proposals along three dimensions. First, how many currently uninsured would purchase health insurance?

Second, what impact would the tax credits have on those that currently purchase private insurance, either through an employer or directly? Third, what effect would the proposals have on reducing the growth in health care spending?

Go to the first issue. How many of the uninsured are likely to use tax credits and purchase them?

According to the Congressional Budget Office, over 19 million uninsured families would be eligible for a tax credit with eligibility limited to $40,000 per year, and nearly $20 million at levels outlined by the President's proposal. Thus, nearly all the uninsured would technically be eligible for a credit.

In 1992 dollars, an individual policy costs yearly about $2,100; the family policies typically exceed $5,000, although, clearly, there are variations across the country.

These credits would finance approximately 57 percent of an individual policy and 48 percent of a family policy. Two sources of data allow us to provide some estimates in the number of uninsured who are likely to take up on these types of tax credits: surveys, and actual observations on how people act in the market.

With respect to surveys, I have seen a number of them and I can tell that they are fairly poor predictors of actual behavior. What I have done is try to rely on results from pilot studies and evaluations that I and colleagues at Harvard have recently completed in New York State.

We have examined the willingness of people to purchase subsidized health insurance, both employers and individuals, at subsidy levels that seem to be similar to those that I just outlined above.

I think the results of the pilot projects that we looked at were somewhere underwhelming, in that fewer than 10 percent of those eligible in the three New York State sites that are focused on individuals actually ever purchase insurance.

The results from the recent experiments which provided similar premium subsidies to those envisions in the President's plan and

other proposals suggest that these voluntary approaches will have limited effect in reducing the number of uninsured.

From what I can tell from these results, a low estimate would be anywhere from 3–4 million, and a high estimate would be something on the order of 10 million. That would leave approximately 23 million people without health insurance.

Second, what effect would it have on private insurance, that is, those individuals that currently have it? Again, since individuals can take tax credits up to incomes that are actually quite high, nearly 75 million individuals who are currently privately insured would have access to these types of credits.

Moreover, the average annual payroll of smaller firms, approximately 2.6 million establishments with 100 or fewer employees that currently offer health insurance, is typically less than $25,000 a year.

Again, there would be strong incentives for those employers to drop their coverage. So, I think failure to lock these establishments in to maintaining insurance would dramatically increase the Federal cost of these proposals, directing most of the benefits to people that already have health insurance at fairly high incomes.

The President's subsidy approach is even more problematic. I provide an example in my testimony showing how the President's plan potentially could shift billions of dollars of currently privately financed premium contributions to the Federal Government, and Federal taxpayers.

Finally, what effect are these proposals likely to have on the growth of health care spending? Most of them rely on managed care and increased cost sharing to limit the growth in spending.

Research evaluating managed care has produced mixed results. It largely depends on the design of the managed care program. Group model HMO's that have been described earlier in today's proceedings really seem to be the most effective, but a mid-range estimate is something on the order of 10 percent reduction in spending.

More aggressive market-based approaches that rely on cost-sharing I think would save some money, but if you look at the results from the Rand Health Insurance experiment, they suggest that even if we had cost-sharing and aggressive price shopping along the lines that Dr. Butler has identified, that would have, at most, reduced the rate of real growth between 1950 and 1980 in health care spending by about 10 percent.

In summary, voluntary tax credits will allow some individuals to purchase insurance. It is likely to have a minor effect on reducing the number of uninsured, and I think they are ill-equipped to address the growth in health care spending.

I also think they have a fundamental flaw in a voluntary system. The higher the tax credit, the more likely you will have more uninsured purchase policies, but you will also disrupt existing private insurance arrangements.

Smaller credits are even less effective in reducing the number of uninsured. The former is not particularly target-efficient and increases Federal cost, and the latter approach results in a small reduction in the uninsured.

Just in closing, I think if you look around the table at a broad range of proposals, the one consistency that I do see is that we should not retain a voluntary insurance system. We do, however, have differences of opinion about who should provide coverage.

But to really address this issue of delivery system reform and cost containment, and, clearly, the uninsured, we have to start from the vantage point that everybody has health insurance. Thank you, Mr. Chairman.

Senator BREAUX. Thank you, Dr. Thorpe.

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

Senator BREAUX. Dr. Butler, I read your proposal as mandating health care insurance. I am surprised that the Heritage Foundation would propose a mandated anything.

Dr. BUTLER. Well, we seem to surprise a lot of people sometimes, Mr. Chairman. But unless you have everybody under a system, you have certain problems. You have got to be prepared, without a mandate on individuals, to say that if somebody chooses not to cover themselves—despite all the help you are going to give them—you will let them live with the consequences.

As a society, we are not prepared to do that. Therefore, to avoid this "free rider" problem, as well as other problems, I think it is necessary to have a mandate. I think it is the only way that a tax credit system, or any other system, can really work.

Senator BREAUX. Your proposal speaks, to a large extent, to giving individuals a greater say, and a greater choice, and more responsibility in making their choices about health care coverage.

And we have heard some discussion and testimony that people are simply not capable of making those choices when it comes to health care. They want the best, they want it the quickest, they want it to take care of the needs of their children, their families, and themselves.

And it is not something that someone sits down and says, all right. Where can I go to get the best treatment for this particular procedure? Can you change consumer behavior in this area, or do you think currently people are capable of making that distinction and the proper choices?

Dr. BUTLER. Let me draw a distinction between two ways in which consumer choice can operate. One, which is envisioned by Mr. Rooney with his MediSave account, that individuals would shop around between doctors, asking for price lists and so forth. I do not think that is ever going to come about, and it mistakes the way in which consumer choice can and should operate.

The other type of consumer choice is something which you, Mr. Chairman, exercise every year, as do the staff members behind you. Each fall you choose a health plan for the following year. You shop around with a lot of information. And if janitors on Capitol Hill, and messengers, and Congressmen and staffers can do this every year, I tend to feel that the ordinary American can probably do that, too.

Senator BREAUX. So, you are distinguishing between the choice between the physicians and the hospitals and the choice of the policy selection.

Dr. BUTLER. Absolutely. And I share the views of the previous panel of Congressmen from the House that picking plans, not treatment or surgeons, should be the basis for consumer choice.

The most effective reform is the one which requires individuals to choose a plan, a basic set of services as set down by Congress, but gives them the freedom of choice to pick which type of system of delivery they wish. Government then would invite entrepreneurs and others with innovative cost-effective methods to provide those services to come forth and bid for each family's dollars.

That is the kind of system that works already within the Federal employee system. It works in the rest of the economy with very complex purchases, such as automobiles. That is the model that can and should apply in the area of health care.

Senator BREAUX. Where is the element of cost containment in that proposal, though?

Dr. BUTLER. The same as in every other area of the economy where consumer choice operates. When an individual is given an array of choices of different prices, different quality, and different sets of services, the cost control is that the providers of those services, those packages that have to compete for their dollars, must find better and better ways of combining quality and price if they are going to succeed in the marketplace and survive.

That is the method of cost control which has been far more effective than any other than we know of, including government price controls, fee setting, and all of the regulatory paraphernalia that we have in the Medicare system. That system of individual consumer choice works much more effectively, it is demonstrated to work more effectively, and I think we should apply it in the area of health care.

Senator BREAUX. So, your cost containment is the marketplace?

Dr. BUTLER. And I am quite comfortable with that.

Senator BREAUX. Dr. Feder, do you have a comment on that?

Dr. FEDER. I would be happy to comment, Senator. I am sitting, wondering what evidence it is that Dr. Butler is drawing upon to show that the marketplace has been so effective.

I think we have far more evidence, both from international experience and from our own States' experience, that rate determination—budgeting and rate regulation—is far more effective than any competition we have seen in controlling costs.

With regard to the general features of the plan and Mr. Rooney's plan that so interest you, I do have a concern. My concern is that advocacy of this approach rests on the judgment that consumers are driving the bulk of health care costs, that consumers choose to use too much.

Senator BREAUX. Well, he would also argue some of the studies show 20–25 percent of it is administrative costs, which could be greatly reduced, too.

Dr. FEDER. Well, the administrative costs are a separate issue and I would talk about that, too, if you wish. But in terms of the cost of services, I think that if we look at medical expenses, we find that the bulk of medical expenditures are going to people who are quite sick and spending substantial amounts, and that those expenditures are driven by physician and other provider choices beyond the control of the individual.

So, I think we can have individuals responsible for some share of their bills, but to put all the weight of the system of cost containment on that design feature, I think, is likely to be decidedly ineffective.

Senator BREAUX. Well, I would just make another comment. Under the legislation I have introduced, we are not shifting at all to the consumer. We are giving that first amount, 3,000, as an example, which statistics show us 94 percent of the people in the country have costs of that much or less a year, but for the amounts above that for consumers for catastrophic problems is there would be catastrophic insurance that would be purchased for that.

Dr. FEDER. Yes. I did not mean to say that you were shifting all the financing.

Senator BREAUX. Yes.

Dr. FEDER. But I think you are relying on that front-end to do your cost containing and I think you have still got a big problem of containing costs in your catastrophic segment.

Senator BREAUX. Yes. Senator Chafee, questions?

Senator CHAFEE. Thank you, Mr. Chairman. Dr. Butler, as I understand it, under your proposal insurance no longer would be either deductible by the employer, nor non-taxable to the employee. Am I correct in that?

Dr. BUTLER. You are partially correct. In distinction to the proposal from the previcus panel, if an employer were to provide a plan as a part of compensation, than under our proposal it would continue to be counted as cost of labor, and, therefore, would be deductible by the employer.

But the full value of that plan, if the employer provided it, would count as taxable income for the employee. Of course, the employee would be eligible for the new tax credit system that I proposed.

Senator CHAFEE. If he fell within the lower income limits.

Dr. BUTLER. Well, it would be a different level of tax credit, depending on his income. But, yes.

Senator CHAFEE. Oh. So any employee would get some tax credit.

Dr. BUTLER. It would be more efficient to have a system in which the tax credit was available only for a basic package and would be scaled back completely for those beyond a certain income. Politically I am not so sure that that would fly.

Senator CHAFEE. Now, I guess there are several arguments against your proposal. First, the argument that you have heard here and you have heard other times, I am sure: the difficulty that the unemployed would have potential insuree would have in making the choice. He is low-income level, low-education level.

And what you are saying is he must go out and purchase the insurance with this refundable tax credit that you are giving him. First, what are the mechanics? How do you make sure that the person sleeping on the grate down here by the Federal Trade Commission is going to get the insurance?

Dr. BUTLER. We are talking about a broad change where the individual would either be in Medicaid, Medicare, or covered by this proposal. The individual sleeping on the grate almost certainly would be under a direct government-sponsored program such as Medicaid.

So, we are not really talking about those individuals making choices so much as the person that is working for a small dry cleaning company today with three employees who has no coverage.

That individual would get a refundable credit, or a voucher, in effect, if he is low-income. And because he or she is not an authority on health care, the person would probably join an organization's plan that they felt comfortable with; maybe a union plan, maybe their church plan.

Senator CHAFEE. Yes.

Dr. BUTLER. In other words, they would likely go to organizations they trust and which would be sponsors of health plans. So that they would not have to depend on their knowledge of the health care system to make a good choice.

Senator CHAFEE. And you point to the fact that the Federal employees health benefits program is an example of how people—many of them from low income, many of them with limited education—can go forward and make their own choices.

Dr. BUTLER. Well, they clearly do. And, as you know, Senator, some of the less-educated persons working for the Federal Government do tend to join organizations or pick union-sponsored plans, such as the Mail Handlers, because they do trust those organizations as being likely to act on their behalf.

Under our proposal, through the tax credit mechanism, we simply would permit that kind of process to occur throughout the country.

Senator CHAFEE. Now, I am probably repeating a question that has been asked you before, but where does the cost containment come in? And, referring back to Mr. Halvorson's example—I do not know whether you were here—I'd like you to comment on the excessive use of the Caesarean operations and how that adds up.

First of all, it is dangerous, but, secondly, the cost is substantial. Where, under your plan, would be the incentive not to do that type of operation?

Dr. BUTLER. Let me answer that in a broad way, then in a specific way, because I think that will answer you fully. The broad way, as I said before, is that when people are choosing between plans and they see the prices, have a fixed subsidy, and are offered an array of alternatives, they have a strong incentive to look for the plan that combines the best quality and price.

Now, when you look at precisely how the cost control works, you then have to look at the incentives for the organizations trying to market those plans. They have a strong incentive to look at all kinds of ways of keeping costly procedures under control, to review costs, and to select physicians and facilities within their plan so as to make the entire plan competitive.

So, the way in which competition really achieves cost control in our type of system is, that it forces the organizers of plans to evaluate the physicians. So if they saw a physician routinely doing Caesareans and pushing the cost up of their plan, you can be assured that that physician either would have to change their procedures or would not be in the plan the following year.

This is the same dynamic as in other parts of the economy where organizers who are trying to market products and services are con-

stantly looking at how to make sure that there is not over-charging or inefficiency within their particular plan.

Senator CHAFEE. Somehow, I have the feeling—and this has been expressed before—that trying to wrestle with health insurance—insurance generally, but I suppose health insurance more than others—is not quite similar to going out and buying a refrigerator, or going out and buying an automobile. Maybe it should be. But I, as a member of the Federal Employees Health Benefit Plan, I find it rather mysterious and am totally——

Dr. BUTLER. Well, Senator, it is not the only mysterious purchase that we all make. Buying a car, I can assure you, is something which I dread. But, the fact is, that in a system where I am allowed to go out and purchase a car I would probably hire the Consumer's Checkbook, here in Washington, to go out and do the bidding for me.

That is the kind of thing that happens under a consumer choice system. So, while the system may be mysterious, the issue is, what system, in general, is more likely to lead to satisfaction and cost control? That is the issue.

And I would argue that it is one like the one you and the members of your staff and other Federal employees have, which permits you to explore alternatives. This introduces a very powerful driving force in the structure of the entire system.

And just as you see in the rest of the economy, it does not require everybody to be fully-informed and to be an aggressive shopper for the market to begin to develop cost-conscious and effective plans. All it requires is a key group of people to be price leaders in those areas. That forces the providers to begin to shape up. It is true in every area of the economy, and it would be true in health care.

Senator CHAFEE. My time is up. I have some more questions, but this round is up. If you want to proceed.

Senator BREAUX. Let me ask Dr. Thorpe one question. It seems like one of the points you are making is that subsidies, and assistance, and tax credits is not sufficient to get people to purchase insurance. They are not going to do it anyway. I mean, how do you know that?

Dr. THORPE. Well, again, the numbers that I was talking about are based on actual attempts to pursue similar approaches in New York State, and, indeed, through a series of demonstrations the Robert Wood Johnson Foundation sponsored where they offered employers and individuals heavily subsidized health insurance packages with subsidies that are very similar to those that are proposed in both the President's plan and some of the Senate bills that you are currently looking at. So, they are based on actual behavior. Some people purchase them. There is no question about that. As I mentioned, something on the order of 10 percent of those that were offered a heavily subsidized policy actually bought them. That leaves the issue of why they did not purchase them.

And a couple of things we found in our follow-up surveys were, one, even with the subsidy levels that we are talking about, as large as they are, for many low-income individuals at 60, 70, 80 percent of poverty, they are fundamentally making monthly decisions about whether or not to retain a health insurance premium

and pay the premium that month, or go ahead and buy bread and clothes; basic decisions that, for some months they will be willing to carry the insurance, other months they just cannot afford to carry the policy.

And the second problem that we found is that, even though today the policies are subsidized, if you have an insurance policy that is going up in the 15–25 percent range and after-tax income going up at 3, 4, and 5 percent, the value of the subsidies quickly erode.

Most of the subsidies were fixed-price subsidies, and unless you are going to radically increase the value of the vouchers year in and year out, you run into problems.

And if I may just comment on this issue of cost containment real briefly, because I think it is really very essential to the questions that you are asking.

One of the things that I note in this debate is that economists are a very closed club. And sometimes I like to think I am in the club, depending on my point of view.

But economists will define the issue of cost containment almost as a tautology; that if you have a market, that the observed rate of growth in spending is the right rate of growth.

It is the tautology that under certain definitions of a market, if you can create a market, whatever number evolves is the "right number" and you have cost containment.

But there are two problems with that. One, is that even though the market-based approaches, such as Dr. Butler's proposal, the Heritage proposal, and Alain Enthoven's proposal try to move us closer to what a competitive market would look like, it falls far, far short of the economist's ideal maxim of a competitive market.

And, as a result, there are still very substantial structural problems in the delivery system and in other parts of the health care market that would deviate us away from a "right rate of growth" under a market-based system.

Secondly, we get into this debate about regulation versus competition. And I think the point is that neither—and they are sort of extremes—are probably "the" desirable proposition. I would suggest that we do have a substantial body of evidence that shows that when you combine regulation with competition that you can have a health system grow at a rate that is within the State product of a particular State.

If you look at figures one and two that I provide in my testimony, I have given you four examples of States that have adopted innovative systems, Massachusetts being an example, where you combine competition and managed care in group model HMO's with a rate-setting structure that I think produce fairly impressive results.

Those all-payer systems have rates of growth that are substantially below what the Federal Employees Health Benefit Plan have been.

So, we get into this false dichotomy of regulation versus competition. I think both are probably desirable. I think it is probably incorrect to think that just because we can invoke some more competitive pressures into the system that everything is fixed and it will be fine.

So, as somebody who looks at economics in its purer sense, even with those fixes, we are not likely to see a market-based competitive market and the economist's ideal ever materialize.

Senator BREAUX. Well, thank you for that response.

Anything else, John?

Senator CHAFEE. Yes, thank you. Just a couple of more questions for Dr. Thorpe. I was astonished. I think in the printed record you said that only 10 percent of those eligible for the subsidy in your study. I think in your verbal testimony you said 7. But, whatever it is, it is very, very low, of those eligible for the subsidy used it. And this is, apparently, a subsidy that New York State gives.

What were those sites? Was there another good health delivery system there? Was it an area where there are community health centers, for example? What were the characteristics of the population; poverty, drug abuse, language barriers, and so forth? Could you touch on that briefly?

Dr. THORPE. Oh. Sure. There were five sites in total for the two different pilots. There was a pilot that was directed towards employers that employed fewer than 20 workers. And then there were three separate pilots that were focused on individuals that had annual incomes below 200 percent of poverty.

The ones that I was talking about in my testimony today were in the three sites. Two of them were in New York City; one in Manhattan, one in the Bronx, and one in upstate New York.

So, the characteristics of those sites are quite different. The ones in New York City did have some opportunity for the previously uninsured to use public hospitals and clinics.

The sites upstate, the public hospital option was not there. There were not, really, the same sort of opportunities to use public facilities in the upstate site.

Language barriers existed, but the health plans, as vendors for this demonstration, were chosen specifically because of their ability and history of dealing with the populations in those local jurisdictions.

There was a large Hispanic population in the Bronx. The Bronx Health Plan had a long history of dealing with that population because they have a Medicaid HMO in the same area.

So, the characteristics are quite different, as is access to other types of delivery systems, such as public hospitals.

The thing that we found perhaps troubling and interesting at the same time was that the results in each of the sites were different. The one upstate had a little bit better results. That was more in the 10 percent range of eligibles actually purchasing; people who did not have access to community health centers and public hospitals.

The ones in New York City where those facilities were available, the penetration rates were substantially lower, perhaps in the 3- and 4-percent range.

Senator CHAFEE. Maybe they did not have any physician to go to.

Dr. THORPE. Well, again, the Bronx Health Plan——

Senator CHAFEE. I am setting aside the community health centers.

Dr. THORPE. Sure. One of the features of the Bronx Health Plan was to bring the uninsured within the same sort of managed care network that the Medicaid population has available in that jurisdiction, which means that you are linking them up with a gatekeeper. So, some of them might not have had the history of having a physician that way.

But one of the things that the Bronx Plan did try to do was explicitly link, upon enrollment, people up with a gatekeeper physician. And the same thing was happening at Roosevelt Hospital in New York City.

It is true that in New York City the history of receiving services has been through the emergency room, and having that link with the physician has been very tenuous. But there were attempts to try to overcome that in the plans.

In the upstate sites, that was less so, because the people in the upstate sites were primarily not receiving primary care services through an emergency room, but were receiving it either out-of-pocket through a physician or during some points of the year they actually did have insurance.

Senator CHAFEE. Dr. Feder, are you an admirer of what has been accomplished by the community health centers? Do you think they are doing a good job?

Dr. FEDER. I think the community health centers are playing an essential role, Senator. Because I would argue that even if we get everybody covered, get everybody an insurance card, we still need to invest in ensuring the availability of providers in some underserved areas, whether they be inner cities or rural areas.

That is what the community health centers aim to do, and I think continued support for that program is critical.

Senator CHAFEE. Well, thank you, Mr. Chairman. Mr. Chairman, I must say, these having been very, very useful. I believe the issues of cost containment, universal access, and quality are all important and vital.

But it seems to me the most frustrating element to try to get a handle on is that of cost containment. I think we can cover everybody, but how to do it without the costs going out of sight and changing what is taking place now in the medical costs of our society is the most challenging, I find.

Senator BREAUX. Well, thank you, Senator. And thank the panel very much for being with us and for their testimony. This will conclude the hearing and the committee will stand adjourned till further call of the Chair.

[Whereupon, the hearing was concluded at 12:24 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF RON J. ANDERSON

Patient care has long been my primary concern. As chief executive officer of Parkland Memorial Hospital in Dallas, and chair of the National Association of Public Hospitals (NAPH) and the Texas Board of Health, I deal with it every day. And as we consider how to resolve the problems with this country's troubled health care system, I cannot help but believe that if we create a system that's good for patients, it will be good for the people of America, the institutions of America, and America itself.

The majority of Americans have repeatedly said they want health care reform.

Businesses are suffering from the escalating costs to insure employees. And employees who have health insurance are worried they may lose it as so many others have before them. Health insurance is tied to jobs, and anything attached to a job is by definition limited. Lose your job, lose your insurance. Or, if you don't lose your job but you or a family member develop a medical problem like cancer, you may become locked into that job—unable to move to a better-paying one because the new firm will not insure a preexisting malady.

Our health care system often does not serve patients well and is on the brink of moral and financial bankruptcy.

Self-interest and turfism must be put aside in determining what is best for patients to be served, because we cannot afford the system as it now stands. Government can't afford it. Businesses can't afford it, and individual people can't afford it. Indeed, health care costs are affecting our nation's competitiveness in the world market. We need fundamental reform; not incremental change which is like squeezing balloons. The costs just bulge somewhere else. The current system is accountable to no one.

Competition hasn't lowered costs and, in fact, may have increased them. Fee for service is not working. The system is rife with perverse incentives that encourage utilization for boutique procedures while discouraging services that actually prevent disease and stop medical problems from getting worse and more costly to treat.

Much of the 1990 measles epidemic could have been averted, for example, if all insurers and health services covered immunizations. Instead, this easily preventable disease killed 68 children in a raging nation-wide epidemic of 26,500 reported cases. Many of the non-immunized children had been seen by physicians in the year prior to the epidemic, but immunizations were not offered. This occurs because our current system is overly dependent on the curative medical model whereas preventive care and public health are underfunded and categorical in function.

Previously, only the unemployed and working poor lacked access to timely health care. Now, individuals of many socioeconomic levels are in a similar strait when insurers deem them or a co-worker high risk.

Particularly compelling are the cases of a Dallas architect with leukemia and a 6-year-old boy who needs surgery to prevent his retardation. Their plight was illustrated to me in testimony before the Governor's Health Policy Task Force in Texas. The architect has sold his house and lives with his parents. His wife must work, and his son, an honors student, has left the University of Texas to help support the family.

The architect takes less than minimum wage from earnings so he can buy group health insurance for his eight-person firm. The firm's premiums now cost more than $8,000 per month—all because he had leukemia. How can the small group insurance market work when experience rating has this sort of impact on small businesses like this and all its employees?

In the second instance, a northwest Texas farmer must sell his livelihood, a farm that has been in the family for three generations. He needs to finance a surgical procedure that will prevent his 6-year-old son from becoming retarded. Children are born with a "soft spot" on the top of their head, but this child was born with the sutures already closed. When premature closure of the cranial sutures occurs, the brain can't grow, unless the sutures are surgical broken during various stages of childhood. In his infancy, the child had such surgery at a cost of $5,000. He now needs the procedure repeated so his brain can continue to grow normally, but the surgery is now anticipated to cost more than $30,000. The farmer is self-employed and does not have insurance. He makes too much money to qualify for Medicaid or the Chronically Ill and Disabled Children fund in Texas. The farmer will have to "spend down" or sell his livelihood in order to meet his child's needs.

While some workers are written out of insurance coverage, the high cost of premiums eliminates millions of others. This includes enormous numbers of lower-paid public employees on the local and state level. Of the 22,000 Dallas Independent School District employees, at least 4,000 cannot afford premiums. Approximately 500 Parkland employees also are in that predicament but we plan to ask our Board of Managers this year to let us devise a plan to cover these employees on a sliding-scale basis.

The nation's more than 1,500 private insurers each employ cost-cutting measures that include second-guessing physicians as well as underwriting techniques to eliminate high-risks.

I was caring for a middle-aged man who had thrombophlebitis in his leg. A similar situation in 1984 almost killed him, causing a severe pulmonary embolism that blocked 75 percent of his two pulmonary arteries. Because of his history, we admitted him. A clerk from his insurance carrier questioned the decision several days later. I explained and reexplained that the previous life-threatening event and his current condition required 10 days of absolute bed rest and anticoagulation therapy as well as evaluation for silent pulmonary emboli (clots floating to the lungs). Nevertheless, the carrier continued to call throughout the patient's hospitalization to check on his discharge date and to "give me permission" to continue his hospitalization. All that second-guessing had nothing to do with quality and didn't save one dollar.

The intrusion of insurers into the health care industry is greater than any government regulations and exacerbates costs. The combination of state, federal and private insurance paperwork constitutes a staggering bureaucratic cost that is part of every hospital's budget.

The cost at Parkland, which is licensed for 940 beds, is approximately $7 million annually. This pays for a small army of more than 300 employees whose only task is to process reimbursement claims and related forms. It must be done if we are to get paid. Parkland is a safety net hospital—a public, partially tax-supported hospital that largely cares for the working poor and the jobless who have no health insurance. About 70 percent of our patients are in that category, and I must tell you our safety net' is running over.

We provide care within a health care system noted for its staggering waste—estimated at one-third of the $800 billion annual health care bill, according to articles published in prestigious medical journals, such as Journal of the American Medical Association and the New England Journal of Health.[1] The waste includes, ineffective care unnecessary procedures, fraud, malpractice-related fees and defensive medicine—that's when doctors order tests just to guard against malpractice. Up to 40 percent of common major medical procedures, such as the 250,000 coronary bypasses and nearly one million Caesarean sections performed annually, are unnecessary,[2] according to published medical studies.

Such waste is occurring at the same time about 34–37 million Americans have no health insurance and 60 million others are believed to have insurance inadequate to cover serious illness. Twenty-four percent of Texans don't have health insurance, affecting half of the state's Hispanic residents. Because the majority of the nation's poor people are African American, Hispanic and of other ethnicities, health care

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[1] U.E. Reinhardt, "On the Economics and Ethics of Rationing Health Care," Decisions in Imaging Economics, Vol. 5, No. 1, (April 1992): 10–16.
A.S. Relman, "Shattuck Lecture—The Health Care Industry: Where Is It Taking Us?" New England Journal of Medicine, Vol. 325, No. 12, (September 19, 1991): 854–859.
S. Woolhandler, D.U. Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," New England Journal of Medicine, Vol. 324, No. 18, (May 2, 1991): 1253–1257.

[2] M.D. Connelly, "Confronting the 'Rights' Issue in Health Policy," Health Progress, (November 1991): 12–16.
E. Friedman, "The Torturer's Horse," JAMA, Vol. 261, No. 10, (March 10, 1989): 1481–1482.

breaks down along racial lines, causing more social inequity. Patients without insurance receive health care through an implicit rationing process that tends to discourage using it. This happens at Parkland and other urban public hospitals through inconvenience and 8–12 hour waiting lines because few other hospitals care for the poor. Reducing the existing waste would dramatically increase access to health care. While I applaud federal efforts to do just that, only fundamental reform can effect the systemic changes needed.

As chair of the National Association of Public Hospitals, I urge that a national health plan and policy be developed that stops giving to one group of people, while omitting others. We should leave the company of countries like South Africa and join other industrialized nations in making health care a right. If we follow what is morally and ethically right, we would logically implement a single payer system. It is the most affordable and would have the broadest and fairest tax support. But it must have built-in controls or it will be as fatally flawed as the current system. Cost-containment reforms should include an outcome-oriented emphasis on technology and delivery of services, tort reform, physician guidelines for standards of care, regional health systems, and negotiated global budgeting and rate-setting for institutions and physicians. We must build in accountability, where the cost-per-recipient per year is known, and annual increases are capped. Managed health care has to be part of the plan.

I realize that national health policy may end up as something different than we may want, but it is unconscionable not to have a bipartisan health plan in this country.

We can learn what's best by studying the states and other countries. A number of systems do not bankrupt their economies, yet surpass our public health efforts in issues as fundamental as reducing infant mortality.

The State of Hawaii has exceptionally low administrative costs that compare favorably with the world's best. Administrative overhead is at 6 percent, largely because it's a system of few payers—primarily Blue Cross, Blue Shield and Kaiser Permanente. Hawaii launched its State Health Insurance Plan in 1974. And after nearly 20 years of providing near-universal health coverage, they are starting to see a healthier population, but it's not just because nearly 98 percent of Hawaiians are insured. Recognizing that health insurance alone wouldn't improve the health of hard-to-reach populations, the state also invested in the public health infrastructure.

We should also study Minnesota's single payer, serve-one-serve-all system, which recognizes that many patients otherwise wouldn't be accepted. This erases the kind of gaming that goes on in Texas and the rest of the country where in some counties no physicians will accept Medicaid patients. Minnesota also is experimenting with physician standard of practice guidelines. My counterpart at St. Paul's public hospital estimates these guidelines can shave a minimum of 10–15 percent from high-cost areas, while improving quality and maintaining access. Standard of practice guidelines are part of Minnesota's tort reform. Malpractice juries are informed when physicians follow or deviate from guidelines. This is expected to reduce the volume of malpractice litigation and costs.

New York is exploring an insurance clearing-house concept, called Unycare. A central board sets policy and streamlines insurance policies, regulations and forms. The state also is imposing community ratings to stop insurers from limiting high-risk categories in the small group marketplace.

Many of these efforts could be applied nationally, as well.

We additionally should make health insurance portable by severing its link to employment. We may have to subsidize some industries to avoid considerable loss of jobs if we opt for a play or pay system. For example, if the farm industry were forced to insure migrant workers, food costs would have to go up and create the equivalent of a regressive, hidden tax for consumers.

Fundamental reform under a single payer system would replace today's arbitrary Medicare and Medicaid fee setting. And global budgeting would force hospitals to manage an annual budget adjusted only for volume of services. This would largely eliminate certificates of need but would emphasize the value of health planning efforts.

Public hospitals have always operated under fixed constraints, and in a single payer system the best of them could lead the nation in developing integrated health systems. Perhaps some will evolve into regional systems—filling the fundamental need to link rural and urban health care. As you know, rural hospitals are rapidly disappearing—133 Texas hospitals have closed since 1980. The majority were rural.

Incentives should be available to encourage affiliation agreements between rural and urban hospitals. Cost-based reimbursement, for example, would compensate for the added cost of delivering life-saving as well as preventive health care services to

rural communities. Even if the single payer option occurs, we probably should expand the legislation for the Essential Access Community Hospital program and the Rural Primary Care Hospital program. These programs currently require states to develop a health care network that provides two levels of care in rural areas, full service referral hospitals and primary care hospitals. We must retool and manage rural resources better through integrated health care systems so upgrades of care can be arranged in an expeditious manner for trauma, perinatal care, burn care and other critically ill patients in rural areas.

We must also reform our medical education system. Our health care delivery system will never be adequate as long as there are not enough primary care givers being trained and supported financially—this includes doctors and allied health professionals. A real difference between the U.S. and Canadian or European health care systems is that the vast majority of Canadian/European physicians are trained in primary care while less than 15 percent of American physicians are. Current policies must change because they stimulate the oversupply of medical specialists.

For decades we have talked about having the best health care system in the world. Now, we need to turn our brag into fact.

While our technology is undoubtedly the best, its applicability is limited to who can afford it. And fewer and fewer of us can. A health policy would continue to allow us to embrace new technologies. But before we pass along the costs, we should know what the technology really buys. What's its purpose? What's the outcome for patients? This is particularly important at a time when we're about to have a renaissance in pharmaceuticals that carry enormous cost as well as power to treat disease. At Parkland, our pharmaceutical costs increased 20 percent per year, for the last two years. Price hikes were the main cause, which a single payer system would prevent.

I urge that a national health policy assures more than high-tech medicine and health insurance. It should promote health and prevent disease by also building a public health infrastructure.

It should guarantee universal access to a socially defined level of care. This should be every citizen's right, not privilege.

Good health is a need-fulfillment right that is a prerequisite for the full expression of many of our constitutional rights. The right to vote and freedom of expression are difficult to exercise when you are debilitated by hunger and compromised by pain or illness.

Health does not happen in a void, nor should national health policy. Providing equitable health care is only a start. We cannot put all our money into health care and expect to have a healthy society. We will remain societally sick if we don't also address infrastructural decay—the accompanying social ills of illiteracy, joblessness, inadequate housing and crime.

Perhaps the violence in Los Angeles would not have happened if the participants had more to lose. If the rioters had good-paying jobs, decent housing and were well educated, there probably would not have been any rioting. They would have found another way to express their disgust with the Rodney King verdict.

Clearly, we must give people more to lose. Our youth are at stake, particularly our minority youth. Indeed, our country's productivity is at stake.

As a nation, we stand at a defining moment. Will we measure up? Will we allow the continued increase of health care costs and the numbers of disenfranchised?

This nation is at a moral crossroads and faces the possibility of losing its soul. How we deal with the health care crisis will determine whether we are mediocre or great.

As a physician, I am expected to do the right thing for my patients, and that's what we should be doing for all of this nation's patients.

We need to finally begin meeting the needs of patients and the communities they live in. We must put selfish interests aside and do what is right by developing a fundamental reform package that makes health care affordable, accessible, comprehensive, competent, and most important, accountable.

Thank you for this opportunity to share my support for a single payer reform for America.

Attachments.

PRICE RATIONING SHUNS SOCIAL JUSTICE [BY RON J. ANDERSON, MD]

Until the relatively recent ground swell of support for national health policy reform, discussions about universal health insurance had stalled on zero for nearly half a century.

Efforts to legislate reform began with President Harry S Truman and the Democratic Party in 1948, when they proposed national compulsory health insurance.[1] [2]

In doing so, they helped forward the concept that health care is a right every American should enjoy.

Unfortunately the notion of guaranteeing a baseline of medical benefits to every citizen didn't get very far.

Today, 16 percent or approximately 40 million Americans have no health insurance,[2] [3] and at least 50 million others have insurance inadequate to cover serious illness.[3] [4] Many of these men, women, and particularly children, suffer preventable illnesses; the direct result of a status quo that tolerates lack of health care for certain groups at the same time it spends staggering sums on high-tech and boutique medicine.

This is the sorry legacy of a trend in this country to allocate health care on the basis of socioeconomic class—a pattern that, as Emily Friedman describes in a scathing review of Medicaid, goes back to the first private hospital in the United States where the "undeserving" poor were separated from the "deserving" poor. There were bad poor and good poor, based on the offensiveness of their illness and social condition.[5]

This ugly habit was formally endorsed in 1965 with the creation of Medicaid—a joint federal-state health care program where eligibility is unrelated to medical need.[5] Like welfare, Medicaid allows state-by-state latitude in the amount, duration and scope of services.[6] The program forsakes universal mandates in honor of a state's right to discriminate according to its own biases. Consequently, costly last-minute, resurrection medicine is usually favored over early intervention and preventive services.

Most of the current proposals for reform continue to build on these fundamental flaws, and few would significantly alter the plight of today's uninsured and underinsured. Many are just cost-shifting schemes based on the "price rationing" that Uwe E. Reinhardt calls "integral" to free-enterprise medicine: the withholding of truly needed health care from those unable to pay.[7]

As long as resources are allocated by socioeconomic status and not medical need or scarcity, ethical problems arise. Ethically skewed proposals seek to preserve existing rationing, which occurs when health care is regarded as a private obligation and public programs contain eligibility criteria unrelated to health status. Implicit rationing occurs everyday through inconvenience and long queues in public hospitals and health clinics because no one else will care for the poor.

This undeclared rationing is more egregious than Oregon's proposal to openly limit care among Medicaid beneficiaries; but neither is ethical in the midst of today's abundance. To be ethical, a scarcity must exist. Indeed, rationing assumes scarcity. The fundamental definition of rationing is the equitable allocation of scarce resources; hardly the case in a country whose annual health care expenditures were more than $700 billion, exceeding 12 percent of our gross national product.[8] [9] [10] This is higher than any other industrialized nation and is expected to increase to nearly $800 billion this year.

Considering that as much as a third of the total cost may comprise waste, fraud and ineffective care,[7] health care providers, insurers, lawyers and bureaucrats obviously are benefiting more than patients, employers or taxpayers who pay for health care.

Administering our bureaucratic system, which comprises more than 1500 private insurers,[11] costs up to 24 percent of total spending.[9] [12] Studies suggest that more than 30 percent of current health care services are unnecessary and could be eliminated.[13] Up to 40 percent of common major medical procedures, such as the 250,000 coronary bypasses and nearly one million Caesarean sections performed annually,[14] are unnecessary.[8] Physician-owners of imaging and testing facilities tend to order four times the tests of non-owners—a clear conflict.[15] Most physicians practice defensive medicine by ordering extra tests to hedge against malpractice. Physicians bilk Medicaid between $6 billion and $16 billion each year,[16] and that's just part of the fraud-related costs of our health care system.

Waste of this magnitude allows the invisible business of price rationing to refuse otherwise deserving women a technology as beneficial as mammography. The United States is saturated with four times as many mammography machines as usage warrants,[7] and the resulting low utilization rate must be subsidized through unnecessarily high fees of $100 or more—usually not covered by insurance. Similarly, the 1990 measles epidemic could have been averted if all insurers covered immunizations. Instead, this easily preventable disease killed 68 children in a raging nationwide epidemic of 26,500 reported cases.[17]

Meanwhile the debate about rationing continues, with each side arguing over whom to exclude; but as Daniel Wikler so aptly describes the ethics of rationing health care, "one loses some debates simply by joining them."[18] Only when health care is every American's right can the debate at last be elevated to an ethical plane.

Certain principles are not debatable; and from an ethics perspective, equal access to a socially defined level of health care should be a right, not a privilege. It is a need-fulfillment right that is a prerequisite for the full expression of many of our Constitutional rights. The right to vote and freedom of expression are difficult to exercise when you are debilitated by hunger or compromised by pain.[19]

For many years, the state of Hawaii has been virtually alone in attempting to correct such wrongs by making health care more equitable among its residents. Hawaii's State Health Insurance Plan is a near-universal program that has been in place since 1974, and its Canadian-like access is responsible for increasing the percentage of insured residents to 98 percent of Hawaiians.[20]

In stark contrast, Oregon's Health Plan proposal completely sidesteps the rights issue and reallocates existing resources in a manner that doesn't affect the wealthy or insured. Only Medicaid patients are affected. The plan's stated goal is to contain costs by providing a baseline of health care to each of Oregon's estimated 400,000 uninsured residents[21] and reducing the overall number of health care measures now open to a smaller Medicaid population. The plan makes more money available to provide the reduced services to *all* Oregonians living in poverty, or so the argument goes.

Clearly, the plan is being funded on the backs of the poor.

By basing the provision of care on non-medical criteria, we are continuing the dubious American trait of blaming victims for their diseases and socioeconomic class. This is a silent and cruel discrimination tool that helps perpetuate inequity, particularly among the races. The majority of minorities are low-income Americans and therefore have limited access to health care.

The United States and the Republic of South Africa are the only industrialized nations that consider health care a privilege, and the parallels of the two nations are shamefully evident. Slacks in both countries suffer higher rates of infant mortality[22]—the death rate of black Americans is 1½ times higher than whites of the same age, and the mortality rate of black infants is Nice that of white babies.[23] This is in addition to a greater prevalence of diseases in blacks, such as tuberculosis, pneumonia and measles, which have been nearly eliminated among whites in both countries.[22]

As long as we tolerate inadequate health care for any of our citizens, each of us is vulnerable to a similar plight. Increasing numbers of us are being eliminated from health care, as exemplified by the current disintegration of the health insurance market for small businesses—employer of half this country's uninsured workers.[24] Insurers increasingly are adopting practices that limit the ability of small groups to obtain sufficient insurance, including dropping a firm from coverage of just one of its employees uses high-cost treatment, such as chemotherapy.

True reform cannot occur as long as health care is a commodity and defined by piles of pills or procedures to be parceled out. It is not a static snapshot of someone's life. It's a fluid motion picture drawn by many social influences and should be viewed as such, if we are to develop a synergy against conditions that create and breed the litany of health care problems facing us today including teenage pregnancy, substance abuse, trauma, and AIDS.

Health care cannot be addressed separately from the collateral social ills of illiteracy, unemployment and under-employment, crime, and unfit housing. As Reed Tuckson, MD, so eloquently stated in a recent interview, "health is the place where all the social forces converge to express themselves with the greatest clarity."[25] The absence of health is personified in babies who don't get enough to eat and children shot as they lay sleeping in their beds or playing outdoors. It's no longer unusual to read about toddlers gunned down, the innocent victims of crazed gunmen or hostile gangs.

What difference is there between killing our children with the stray bullets of drive-by shootings or the miserable public health neglect that kills with measles? Taking our lead from Emily Friedman, who quotes Raul Alfonsin, the first civilian president of Argentina after the military dictatorship fell in 1983, we should ask, "When a country kills its own children, shouldn't we admit we have touched rock bottom?"[17] When will we hold ourselves to a higher standard?

We should begin by acknowledging the value of every citizen—implicit in guaranteeing basic health services to everyone.

Fundamental to reforming our health care system should be the equitable, managed health care concepts of outcome, utilization review, and continuous quality improvement. Through rational reforms that rid the system of defensive medicine, excessive bureaucracy and other waste, price rationing won't be necessary.

But in doing so, we also will have to reform our thinking, viewing the poor through a new pair of glasses that permit us to see them as an opportunity, not a social burden. By acknowledging the value of each citizen's humanity, we will rise

above the "us and them" mentality that now permits us to step over homeless people sleeping on the sidewalk. When we begin to do something to reduce the physical suffering of others, true reform of our health care system can occur. Perhaps that's where the Canadians have risen above us. They seem to value people more than we do.

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Community Responsive Medicine: Defining an Academic Discipline

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ABSTRACT: Academic medicine is entering a period of introspection created by changing patterns of health and disease and changing patterns in reimbursement and health policy. To respond to existing health challenges, innovative strategies for health care delivery and education must be devised. The migration of medical education and health care delivery into centralized and frequently difficult-to-access campuses is being reviewed by payors, policy analysts, and purchasers of care. One proposed solution to this problem responds to the identified shortcomings in medical education and some of the failures of our health care delivery system. Community Oriented Primary Care (COPC) and the related discipline of Community Responsive Medicine define health-oriented strategies that blend traditional primary care and public health. The classroom in Community Responsive Medicine is the community. The curriculum is defined by the elements and skills necessary to improve the health status of the target community. The model allows the student and resident to appreciate and experience the entire spectrum of health and disease and to understand the sequence of events that may lead to illness. Tertiary care is a critical curriculum component, but in Community Responsive Medicine the curriculum is balanced between the ambulatory and tertiary care settings. Community Responsive Medicine defines a role for new leadership that can create responsive educational and health care delivery systems accountable to the communities they serve. KEY INDEXING TERMS: COPC, Community responsive medicine; Involution; Discipline. [Am J Med Sci 1991; 302(5):313–318.]

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Nationally, the underuse of ambulatory care and preventive health services has placed significant demands on public hospitals and emergency rooms.[1,2] Barriers to access, both financial and nonfinancial, as well as the failure of medicine—particularly medical education—to promote, reinforce, and teach comprehensive community-based primary care have contributed to this inappropriate pattern of health care use. This pattern bypasses the most cost-effective and health effective services that can be provided in the community.[3–6]

Community responsive medicine represents the academic discipline of Community Oriented Primary Care (COPC). COPC is a health-oriented strategy that blends traditional primary care with public health services.[7] Primary care, the structural foundation of COPC, can be defined as the array of health services provided by a practitioner to a patient that are accessible and acceptable to the patient, comprehensive in scope, coordinated and continuous over time, and for which the practitioner is accountable for quality and potential effects of the services.[7,8]

The distinguishing characteristics of COPC emerge from its community focus. COPC defines the geographic and demographic characteristics of its target community and applies health resources to respond to identified needs. Critical to the concept is the community's active participation in problem identification and prioritization. The effectiveness of the program is measured in terms of its impact on the health status of the target population.[7,8] In public health terms, COPC is a denominator-driven system that ultimately assesses effectiveness through a formal epidemiologic evaluation of the population at risk.

Community responsive medicine minimizes fragmentation by reducing barriers such as transportation or cultural insensitivities. This concept embraces the concept of "one-stop shopping," which promotes the colocation of related services, such as laboratory, pharmacy, radiology, health education, Women, Infants and

Children (WIC) feeding program, surveillance, and immunizations.[9]

Community responsive medicine seeks to define a discipline that merges the art and science of medicine with the concept of health or wellness. The components of this discipline have been incorporated in only a handful of academic campuses nationwide. However, changing patterns of health policy and reimbursement may herald a significant redirection in medical academic priorities toward community responsive medicine.[7,10]

Involution of Medicine

A number of interrelated factors contribute to the need to embrace a new academic discipline that can provide medical education in a community setting, promote health, and be responsive to the needs of the at-risk populations.[11,12] Despite some recognition from academia, public health, and the payors of care that community-based educational strategies should be supported, significant barriers exist. Medical education has been delivered predominantly in large, centralized medical centers and campuses.[4,10–12] During the last century, health care delivery has undergone a process of involution. This has brought most components of health care delivery geographically closer to the medical classroom. The process of involution has prompted the migration of health service delivery away from the community and population at-risk to within close proximity of centralized medical centers and academic campuses.

At the same time, a parallel phenomenon of compartmentalization has occurred. Subspecialization of medicine into organ and sub-organ specific departments was fostered by reimbursement reforms and the supporters of research.[2,13] From the mid 1960s and to the late '80s, medical knowledge benefited from an algorithmic growth in scientific advancements and an era of unprecedented investment in medical technology. Medicine failed to effectively coalesce these compartments of knowledge into a continuum of medical education that enabled students to see the sum of the parts.[14] Concomitantly, the health care delivery system adopted this compartmentalized approach to medicine. This fostered a categorical response to care and imposed further barriers to patients seeking help for problems that cut across more than one organ system. Because of these trends, the practice of medicine did not become synonymous with improved health status or functionality.

The financing of medical education and research provided great impetus to these two parallel processes of involution and compartmentalization. Trends of health care financing in the 1960s, '70s, and '80s created a wide schism between health and medicine. Medicine increasingly focused on diagnostic technologies and curative tactics.[13–15] Preventive strategies and community and public health were largely neglected by medical educators. The academic system failed to create or cultivate role models who could reverse these trends. The process of involution amplified many existing financial and nonfinancial barriers to care, such as transportation, and significantly affected the health-seeking behavior of such subpopulations as the frail elderly, school-aged children, the working poor, and pregnant women. The migration of care away from the community has been convenient for the educators, researchers, and providers of care, not for the seekers of care.

The Problem

Current patterns in medical student applicant pools, residency selection, reimbursement strategies, and the organizational structure of academic institutions have amplified the effects of involution and compartmentalization. Fewer students are applying to medical schools, and still fewer select primary care residencies.[15,16] In 1974, 42,624 students competed for 15,066 first-year positions in medical schools, while in 1988 26,278 students applied for approximately 14,000 positions.[16] During the same period, there was a decrease in the percentage of senior medical students selecting graduate medical educational opportunities in primary care. Expressed interest of medical school graduates for primary care specialties declined significantly from 1981 through 1989.[16–18] The reduced interest was noted in family medicine, pediatrics, and general internal medicine. Among the graduates who do select a primary care residency, an ever increasing percentage are receiving advanced training in one or more subspecialties. These trends have contributed to a diminishing pool of practicing primary care physicians nationwide.[15]

Since 1963, the ratio of primary care physicians to population and the percentage of physicians in primary care have decreased. The ratio of office-based primary care physicians to population was 53 per 100,000 in 1963. The national response in 1963 to this information was to implement legislative and policy reform that would improve the number and distribution of primary care physicians throughout the following two decades. These changes included escalation of the National Health Service Corps and the direct support of primary care residency programs through federal grants.

In 1986 the ratio of primary care physicians to population remained relatively unchanged—52 per 100,000. Primary care physicians represented about 50% of all physicians in 1963 as opposed to 34.3% in 1986. During the 1980s the federal government responded with cuts for both of these programs initiated during the 1960s.

While data suggests there is a shortfall of primary care physicians, numerous disincentives and barriers throughout the health care industry impede efforts designed to change the status quo.[11,12,14] Current reimbursement strategies are inpatient and procedurally oriented and do not provide sufficient financial incen-

tives for expansion of ambulatory medical education.[13,15] Patient revenues have contributed an ever increasing proportion of support for undergraduate and graduate medical education over the last 3 decades. Because of direct and indirect acknowledgement of these costs in programs such as Medicare, inpatient services have contributed the largest share of the revenue that can be directed to medical education. Better reimbursement margins for high-tech diagnostic intensive care and inpatient services continue to reinforce the teaching of medicine in tertiary care centers. A shift from an inpatient-dominated curriculum to a balanced inpatient and ambulatory curriculum would reduce revenues and the ability of institutions to cost shift educational expenses.

Medical research has shaped medical curriculum, improved our ability to diagnose and treat disease, and has greatly contributed to the body of medical knowledge and the tools required to practice medicine. The present structure and focus of research awards also have directly influenced the content and the location of the academic classroom for undergraduate and graduate medical education. From 1960–1983, the National Institutes of Health and other granting institutions and foundations significantly expanded the direct and indirect support for medical education. Federal support for medical schools (29%) represented the second largest revenue contribution to medical education in 1987–88, second only to patient revenues (39%).[15] Parallel with the growth of revenues from these two categories has been an unprecedented explosion of technological advances in medicine. These advances prompted a substantial investment in centralized campuses and medical centers and created a disincentive for developing community-based curriculum or faculty. The greatest benefactors of this knowledge and technology were the sickest patients who were able to access the centralized campus. There has been disproportionately little trickle-down of this knowledge to community- based care and preventive medicine.

The organizational structure of most academic faculties has substantially influenced medical education. The decentralized departmental structure of most medical schools creates an environment that compartmentalizes curriculum and knowledge and in which ambulatory care is more often a burden than a priority. This dominance of structure over ideology predicts patterns of tenure and promotion within the faculty. Departmental dominance generally parallels the relative contribution of that department to patient-derived revenue and research grants.[14]

Changing Incentives

Increasing attention has been recently directed to the need for curriculum reform and the development of compatible incentives.[4,6,11–13,19] Preventive and early intervention strategies for patient care are gaining stature as critical elements in our armamentarium against disease. The public sector, which has completed the health objectives for the year 2000, and the private sector have brought attention to the concepts of health promotion and disease prevention. Managed care in some areas of the country has marketed preventive strategies successfully. Medical education has generally lagged behind.[3,4,20,21]

Academia has begun to recognize a changing pattern in the severity and acuity of illness. Patients are being admitted to hospitals for shorter and shorter periods of time as the hospitals attempt to decrease the average length of stay (ALOS). These changes, partly in response to changing reimbursement strategies under Medicare, provide medical students with a shorter glimpse of the patient, his or her disease, and the effects of therapeutic interventions.[6,15,21] For the student or resident, a hospital admission becomes a task-oriented encounter with few diagnostic or therapeutic decision points. Many of the opportunities for medical students to understand the pattern of disease and wellness have been transferred to the ambulatory setting. However, students or residents rarely receive adequate exposure to ambulatory settings where a continuum of health, disease, and illness can be appreciated or exposure to an appropriate role model can occur. As a result, a medical curriculum has been promulgated that provides an inadequate transfer of knowledge and experience and in which preventive strategies remain inadequately understood, practiced, or experienced.

Clinical clerkships recently have come under criticism from students. Although a cornerstone of many academic medical schools, the clinical clerkship in internal medicine has been characterized as a course in "advanced pathophysiology."[17,19] In a recent analysis of graduating medical students, respondents stated that because of the changing milieu of hospital-based medical practice, they are exposed only to the sickest patients who increasingly require the care of senior residents and fellows, while medical students often become superfluous to task-oriented care.[12,15,17,21] There is little exposure to health-effective or cost-effective medicine, and students are often relegated to "scut work." Because of the falling number of applicants for most primary care residencies, these concerns are drawing increasing attention.

In addition to a concern that the number of primary care physicians may not meet the health needs of the country, geographic issues are providing incentives for a rethinking of medical education and the skills required to initiate change. Both urban and rural solutions are needed in health care. The inner city and rural America provide unique challenges to practicing physicians. Increasingly these challenges require that physicians acquire a better understanding of the entire community and associated risk factors that contribute to health and disease. Successful physicians must be able to access and interact with a broader array of re-

lated health and social services to improve the health status of the community.

Business has long been a leader in health and health care innovation. It is beginning to recognize distressing trends relevant to the labor force for the years 2010–2025. Projections show that the labor force will become increasingly Black and Hispanic but that current health trends and mortality rates in minorities, if not corrected, might require the nation to export jobs or import labor. To respond appropriately to this need, the location of health services and the sensitivity with which care is given must change. To accomplish this, cultural and ethnic barriers to delivery of care must be addressed at the earliest opportunity and continually reinforced during medical education.[3] Many advances in minority recruitment and retention in medicine have been insufficient, and over the last decade previous gains have been diminished.[22-24] Current efforts to train minority health professionals in medicine need to be enhanced. Curriculum reform must respond to this need and acknowledge and discuss cultural barriers to health care. Ambulatory care strategies will be a part of this response and will confer the secondary benefit of providing role models for the youth of these communities.

The need for accountability within medicine will influence medical curriculum.[3,25,26] Health outcome research and outcome standards are being promoted by those who pay for health care and those who regulate health care delivery. Accreditation organizations such as the Joint Commission on Accreditation of Health Organizations (JCAHO) are instituting quality assurance programs that embrace outcome evaluation. Many hospitals are embracing quality improvement philosophies that go beyond the concepts of quality assurance. To meet these evolving requirements, future graduates of medical schools will require a broader array of skills, such as developing and managing health status indicators. This need will be greatest for those who choose to teach and train others but will also be very real for physicians who choose a purely clinical practice setting. It is clear that the needs and incentives that shape medical education are changing, and there is concern that medical curriculum as currently structured does not adequately prepare physicians for the challenges they now face.[6,27] In addition, changing financial environments may force us to rethink our current system of medical education. The development of innovative community-based curriculums will require leadership, role modeling, prepared and enthusiastic educators, and an appropriate setting for such training.

The Response

Any reform in medical education will depend upon the development of leadership that will assert its vision.[4,8,11,12,19,22] To foster and nurture local academic leadership, the current dominance of structures over ideology must be reversed. The present hierarchy of research over clinical tracts must be better balanced. The net worth of both pursuits must be weighed individually and held accountable for pre-established objectives and outcomes. Tenure, if it is retained as an incentive, must be applied equally to promote accomplished faculty members in both areas. In addition, career advancement and development must exist even after tenure is offered.

To successfully respond to the health care challenges outlined, a restructuring of the medical curriculum is needed so individuals with the appropriate experience and skills in community responsive medicine are developed. Several authors have defined and established curriculums that are responsive to these needs.[6,19,21] In general, such a curriculum cannot be structured as elective time. The experience must approximate as closely as possible the actual day-to-day practice of community responsive medicine. At the skill attainment level, additional time must be devoted to public health and health policy. Specifically, students must have a broader understanding of public policy, public health, preventive medicine, biostatistics, epidemiology, and ethics. Coursework in teaching students to teach would benefit their role as health educators in community responsive medicine. Experience in developing and implementing health and social service programs at a community level should be mandatory.

The Centers for Disease Control of the Department of Health and Human Services have long had a practicum in epidemiology and biostatistics that engenders these basic skills and provides a community classroom for their application. The breadth of experience and understanding derived from this approach has been significant and could provide a model for academic institutions.

While there has been substantial discussion and development of model curriculum, less work has focused on where this classroom should be situated to accomplish this reform in medical education. There is a model of community practice that can provide an ideal setting for both undergraduates and graduate medical education—Community Oriented Primary Care (COPC), which represents a melding of primary care practice and community public health.[3,7,8] There have been several successful applications of the COPC concept in this country. Seven case studies, including urban, rural, and academic models, were reviewed in a report published by the Institute of Medicine in 1983.[7,8] While most of the systems described had not implemented all aspects of COPC, all had defined their target community through a needs assessment process and were providing a wide array of related health services either directly or through contractural arrangements. The success of two programs, one in Tucson, Arizona and another in Oregon, provided the needed impetus for the revitalization of their departments of community medicine and the expansion of the academic curriculum to include a community-based classroom.

In 1986, Parkland Memorial Hospital defined an ambitious strategy to better serve the health care needs of the residents in Dallas County through the establishment of a community-based care system. Recognizing the increasing demand for ambulatory care and education on its congested central campus, which it shares with the University of Texas Southwestern Medical School, Parkland adopted the concept of COPC. The hospital obtained county tax support for this initiative, designed to improve the delivery of comprehensive primary and preventive care within the communities at risk and to decongest the central campus. The program was implemented in 1989 and currently focuses health services in 6 at-risk communities in Dallas County that were targeted in a county-wide needs assessment conducted by Parkland. Physicians working in these health centers and the community are granted faculty status by the university and provide attending coverage on the inpatient units of Parkland Hospital and Children's Medical Center. In addition to providing unique inpatient and ambulatory teaching opportunities, this arrangement enables the COPC program to provide continuity of care for the practice and inpatient settings. The program operates 6 health centers and extends care into a variety of nontraditional settings, such as homeless shelters, schools, churches, and elderly activity centers. This configuration generated over 110,000 patient visits in 1990. By 1993, over 200,000 patient visits are anticipated.

As a secondary gain, it was hoped that the ambulatory setting within the central campus could become a referral system for the COPC program. It was expected to evolve as an ambulatory care center of excellence that could more appropriately focus on subspecialty- and technologically dependent ambulatory medicine. Initial evidence indicates that the centralized ambulatory care center is being used by the COPC program as a subspecialty referral system while continuity of care is maintained at the community level.

To create an appropriate mechanism and atmosphere for the physicians practicing and teaching in COPC, a unique group practice was established. This multi-specialty group, Community Health and Medical Primary and Preventive Services (CHAMP²S), had as its original challenge the need to recruit 20 physicians during the first year. This recruitment goal was met and surpassed, as 23 physicians were hired during fiscal year 1990. The group is ethnically diverse—Black and Hispanic physicians account for 56% of its membership, women account for more than 65% of the group, and 5 members possess advanced degrees in public health or fellowship training in clinical research. Clinical faculty status was negotiated for the group members in their primary specialty and in the Department of Community Medicine because only University of Texas Southwestern faculty can admit to Parkland. The group fills a critical void by "role modeling" primary care and public health to medical students, residents, nursing students, and allied health professionals. The cultural and ethnic diversity of the group provides an additional opportunity for "role modeling" within the minority communities served by the program.

Perhaps the most innovative component of the group practice is the linkage of an incentive pay program to the achievement of health outcomes. Health status objectives are delineated that address health problems identified by the health center staff and the community leadership. Outcomes are linked to known effective strategies for preventive health care. An example of such a targeted outcome might be a 10% reduction in morbidity and mortality related to breast cancer in the targeted community through the application of breast self-examination classes and screening mammography. Progress toward achieving this outcome is monitored through data sources such as the Parkland Tumor Registry and the hospital's Patient Management Information System. A variety of outcomes and process measures are selected each calendar year and tracked longitudinally. Incentive bonuses are paid when objectives are reached.

Preliminary evidence suggests that efforts to redirect health care (not just medical care) back into the community have improved the health of the community. Data show that since 1968, when the predecessor of our program—the Children and Youth Project—began in West Dallas, inpatient admissions from West Dallas have fallen, teenage pregnancy in the Hispanic and Black communities has declined, and death rates for adolescents have been substantially reduced.[3]

Conclusion

To respond to future health challenges, innovative strategies for health care delivery and education must be devised. First, the current pattern of patient care delivery must be revised, in which an infrastructure is created primarily to support the needs of medical education and research and that only secondarily responds to the needs of the patient. The health status of the patient and perhaps the community must be the first priority of the system. Also, a greater proportion of medical education must be accomplished in a more functional setting designed to improve the health of the patient.

Second, medical education needs to embrace a health model as opposed to a medical model, which often narrowly focuses on pathophysiology. The incorporation of a health-oriented curriculum will define new academic elements, such as epidemiology, ethics, prevention, surveillance, biostatistics, and public health, for study by students and residents. Third, medical education must adopt a curriculum that will promote a change in classroom venue. A more balanced curriculum is required to develop physician competencies in the centralized tertiary care center and in the community setting. Recent surveys indicate that graduating

residents often feel inadequately prepared for community-based practices.

Finally, academia will be called upon to forge roles for new "town" physicians or clinical faculty who can provide effective primary care leadership and become tenured role models. The mix of patients who become "teaching material" is changing as paying patients with a choice avoid teaching institutions. Linkages with a new generation of "town" physicians (such as CHAMP²S's group practice) will improve educational opportunities in the community as well as increase revenues for the medical center. Maintaining a diverse patient mix will allow teaching hospitals to evolve as systems that are more patient centered and that deliver care in a fashion that is valued by patients.

Academia must be cognizant of the potential for significant reform of the health care reimbursement system that could create a system of choice for all patients. As educators, we must not only establish the appropriate content and location for the medical curriculum, but determine whether we are supporting the development of delivery systems that could be maintained if a majority of our patients could choose where to receive care. Furthermore, we must identify and implement the system most likely to provide the greatest impact on the health status of our communities and best prepare young physicians to meet existing and future health challenges.

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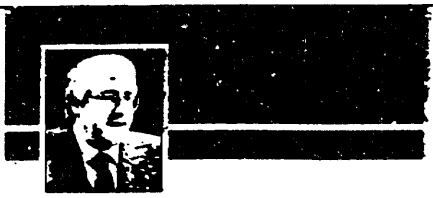

Repairing the Texas Health-Care Safety Net:

The Tyranny of Urgency or a New Pragmatism

BY RON J. ANDERSON, MD — Tyler, Texas

Health care entities in rural and urban areas of Texas have traditionally functioned as separate systems of care,even though lately they are battling similar financial problems.

The state's health-care crisis is naturally increasing the difficulties, but it also is providing the opportunity, indeed the impetus, to weave these two health care safety nets into a coordinated system for the benefit of all Texans.

The impetus for big-city hospitals is that they are now feeling the full impact of some unavoidable financial woes that closed nearly 100 smaller hospitals during the 1980s. More than 60 of these were rural hospitals — 54 Texas counties do not have a hospital and another 67 each have only one hospital with less than 50 beds. Indeed, these latter facilities are an endangered species.

The lack of equitable reimbursement from Medicare and Medicaid and shrinking local tax bases are making it tougher for inner-city public and rural hospitals to continue to meet patient's needs. The only factor that remains constant in the worsening funding crunch is the relentless increase in the volume of indigent and uninsured patients, contrasted against a decreasing ability to stay ahead of rising costs.

The problems of inner-city public and nonprofit hospitals are reflected in the closure and threatened closure of emergency rooms, municipal ambulance systems that are on "overload" most of the time, and the need for "diversion" policies in times of staffing shortages, when hospitals are over capacity or when further demand would seriously jeopardize patient care.

At Dallas' Parkland Memorial Hospital, which is a Level I Trauma Center, we have emergency room patients waiting two days after admission before we can move them from the ER to a hospital bed. We certainly have the capability, but our capacity is not sufficient to meet the demand. Inner-city violence and drug wars have markedly increased the trauma load for the hospitals participating in Dallas' trauma network.

Because of their size, the capacity problems of urban public and nonprofit hospitals may not be so apparent to the general hospital administrator or general practician. But the gap is very real and probably affects many rural people needing transfer for critical illness or injury.

The extent of the inner-city problem was dramatically illustrated in Houston last year when Hermann Hospital dropped out of the emergency room business, leaving Ben Taub, the nearby public hospital, absolutely chocked by the overflow of patients.

Hermann said its decision to close off ambulance traffic was intended to stem the revenue drain of unfunded trauma patients, who require intensive nursing care a costly factor during a nationwide nursing shortage that demands providing increasingly competitive salaries.

The problems caused by such measures in rural and urban areas constitute more than an indigent care issue. They are healthcare issues that potentially affects us all. Lifesaving

(continued on page 18)

trauma services are just as necessary for the wealthy rancher or businessman injured in highway accidents as they are for the Saturday knife-and-gun-club patients.

For the well being of all potential patients, we should begin working together for legislative support to create mutually beneficial systems of care for urban and rural areas of defined regions within our state.

Many possibilities exist for broadening the health care safety net, but so far, we have been trying to address capacity and capability issues in a disjointed manner without adequate state support. This must change.

We need a legislative package that gives urban public hospitals incentives to help endangered rural hospitals through a backup system of tertiary, medical, neonatal and trauma care services. The assistance could also be in the form of "managers on loan" or purchasing agreements to help keep rural hospitals fiscally sound. The incentive package should become the needle and thread to sew the rural/urban safety net together. Without adequate funding, it is unlikely that such systems will evolve despite the progressive rural health legislation of 1989. (House Bill 18 by Rep. Mike McKinney, M.D., D-Centerville.)

Another possibility is to consider retooling some rural hospitals into Medical Assistance Facilities, (MAFs), in the manner now being implemented in Montana. Such programs require changes in regulatory and reimbursement systems to allow them to handle some types of hospital care for a limited period. The program must include transfer arrangements to larger facilities. Further, the program uses mid-level practitioners and physician extenders to maximum benefit. Medical Assistance Facilities clearly would be better than the void created by the closure of hospitals in many Texas communities. In fact, years ago some communities might have been more interested in the creation of a rational rural health care system if Hill-Burton money had not focused so narrowly on hospital construction. The availability of the money encouraged every small town's Chamber of Commerce to press for their own hospital.

Another concept that could cost-effectively be adapted to existing rural facilities is the Community Oriented Primary Care program (COPC) currently being implemented by Parkland. COPC is a series of neighborhood health centers that focus on disease prevention through primary care, public health and disease prevention blended with health education. One of its most attractive features is that it reduces illness and, consequently, future demands for costly secondary and tertiary care. In rural areas, the program could be linked to a referral net-

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U.S. Congress

BY JIM CHAPMAN

Jim Chapman

Member of Congress
Sulphur Springs, Texas

As a result of my membership on the House Appropriations Committee, I am directly involved in the development and implementation of our national health care policy. The Appropriations Committee has the authority to control and allocate expenditures, and therefore, has a direct impact on our nation's health care system.

Furthermore, with 14 years experience as counsel for the Hopkins County Memorial Hospital District and my sincere concern for the availability of health care in rural America, I have a deep understanding of the rural medical community. With this background, I have taken a leading role in the House Rural Health Care Coalition. The 144 member strong coalition is the most vocal advocate for rural health care in the House of Representatives. Through the Coalition, I can concentrate on the rural health agenda for East Texans and America. Recent Rural Health Coalition successes include increased payments to Medicare-dependent small rural hospitals and increased recruitment efforts for physicians and nurses to serve in rural and underserved areas.

I see my role in Washington as serving as an advocate and liaison for rural health providers. In March, I held a Congressional Forum on Health, in conjunction with the Hopkins County Chamber of Commerce, to bring the health care debate to the First Congressional District. Doctors, hospital administrators, nurses and other East Texans joined including, Congressman Mike Andrews (D-Texas), Congressman Carl Pursell (R-Michigan) and Jerry Sconce, Regional Director of the Health Care Financing Administration joined me to discuss the critical needs of our region's health system. A majority of my efforts are the result of my constituents' concerns regarding the problems they face in their practices or hospitals. This Forum allowed me an opportunity to gain a stronger understanding of the current situation in East Texas.

For example, problems associated with the Texas Medical Foundation's post-procedure certification process came to my attention as a result of letters and calls I received from physicians in East Texas. I contacted the Secretary of Health and Human Services to express our objections and concerns on the certification process and successfully persuaded HHS to

Case Challenge

A 27 year old Caucasian female was evaluated in 1987 because of recurrent nausea and vomiting. She had been well until approximately two years previously when she noted the insidious onset of nausea with occasional vomiting. The nausea was not constant but would occur during at least part of every day. It did not seem to occur at any particular time of day. It was not affected by position or food intake. The patient had undergone an extensive evaluation elsewhere. Laboratory data had included a normal CBC, sed rate, SMA-20, urinalysis, and amylase. An esophagogastroduodenoscopy, small bowel series, flexible sigmoidoscopy, barium enema, abdominal ultrasound, oral cholecystogram, nuclear gastric emptying study, abdominal/pelvic and head CT, and chest x-ray were all within normal limits. The patient was told that her illness was psychogenic in origin. She then sought a second opinion.

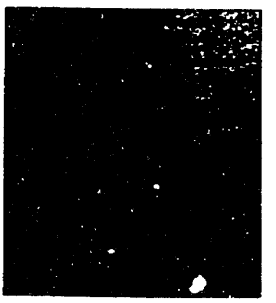
The patient was otherwise healthy. She was married and worked full time as a secretary for a construction firm. She and her husband denied any excess stress or emotional problems. She had a healthy five year old daughter. There was no history of travel. She did not smoke or drink and took no medications on a regular basis. Metoclopramide was used occasionally with variable results. Her family history was unremarkable. She had no unusual childhood illnesses. There were no known allergies. She had no pet or animal exposure.

The patient denied anorexia but reported a 10 pound weight loss. There was no history of fevers, chills, or night sweats. There was no history of GI bleeding, dysphagia, peptic ulcer disease, pancreatitis, hepatitis, abdominal pain, or change in bowel habits. The patient denied headaches or visual symptoms. Her periods were regular. There was no history of urinary, cardiac, or pulmonary symptoms.

Her temperature was 98.5 degrees. Her pulse was 70 and regular. Her blood pressure was 105/65 without orthostatic change. The respirations were 22. The patient weighed 120 pounds. The patient was a well developed female in no acute distress. The skin was normal. Pupils were equal and reactive. The sclerae were anicteric. The fundoscopic exam was normal. The mouth exam was normal. The neck was supple. There was no lymphadenopathy or thyromegaly. The lungs were clear. The heart exam revealed no murmurs, gallops or rubs. The abdomen was soft, flat, and non-tender. No masses were noted. Rectal exam revealed heme negative brown stool. Neurological exam was entirely normal. The extremities were without cyanosis, clubbing, or edema. Laboratory data revealed a white blood cell count of 9.2 thousand with a normal differential. Hct was 39% with normal indices. Platelet count was normal. Sedimentation rate was 14. Urinalysis was normal. SMA-20 was normal. A diagnostic test was performed. Consider these questions:

1. What was the diagnostic test?
2. What was the diagnosis?
3. What was the recommended therapy?

Please see Dr. Seever's issue for answers.



Repairing

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work of urban hospitals.

But most importantly, we should urge our Legislature to begin planning for a "state of readiness" that addresses trauma, neonatal intensive care and other tertiary care illnesses that require a higher standard of capability than smaller rural facilities will ever be able to handle. Such a plan should link rural and urban areas into a unified system of care. Currently, the farther you travel from the Level I and Level II Trauma Centers of major urban areas, the greater your chance of dying if you are critically injured. Studies of trauma deaths in and around Dallas County show that individuals severely injured two counties away from Dallas are 35 times more likely to die from their injuries, compared to Dallas residents who suffer similar injuries but have access to critical trauma care. Systems to deliver such care must be established before all existing capacity in rural communities dries up for good. Further, any healthcare system developed must make good business sense for

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everyone involved or it will not survive.

In addition, tort reform also must be addressed.

Malpractice claims are driving family physicians and even obstetricians out of obstetrics — 116 Texas counties now lack obstetrical services. Similar problems exist for emergency physicians and surgeons dealing with severe medical emergencies or trauma. Only modest help was provided by House Bill 18 in the last legislative session.

Funding must be built into the infrastructure of any system of care. Perhaps a state blockgrant approach or enhancing Medicaid disproportionate share could help undergird the cost of such a rural/urban safety net. This should be in addition to expanding payment for the disproportionate share of services a few hospitals provide to certain types of patients, such as AIDS patients. This is a critical need because reimbursement is woefully inadequate in Texas, and this burden is undermining the ability of urban safety net hospitals to respond to other critical health care needs. Last year, for example, Parkland spent $9.6 million providing care for persons with AIDS.

The AIDS epidemic probably will not spill over into rural hospitals to any great extent, but the high cost of just a few such AIDS patients could economically break some rural facilities. At Parkland, we have learned a lot about providing care to AIDS patients, particularly the importance of developing a continuum of care. We work with over 40 community agencies involved in caring for AIDS patients. These efforts also could be applied to the long-term care needs of elderly in either urban or rural settings or, for that matter, to the transfer of patients in either direction. For rural patients, such a continuum would create care at the right place, at the right time, and the right cost.

But no matter how innovative we are in trying to solve our problems by building regional healthcare systems, we will have to deal with the issue of health manpower. The shortage of nurses is critical state-wide.

At Parkland, we cannot open beds because of it. Currently in the Dallas-Ft. Worth area, several thousand nurses are sorely needed for funded

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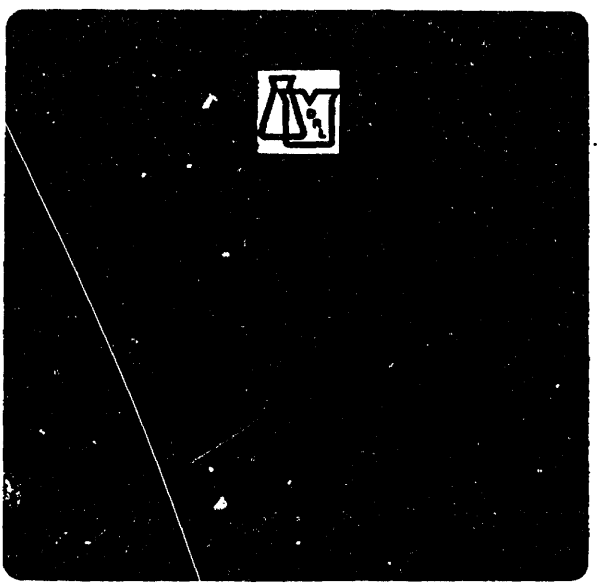

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vacancies. But as bad as the problem is in big cities, the nursing shortage is absolutely critical in rural areas which account for 20 percent of the state's population but have only 10 percent of the state's nurses.

The shortage of many types of allied health professionals is even worse.

Progressive legislation is needed to provide state funding support for community college districts and universities so they can beef up their training programs for allied health professionals as well as nurses. Student waiting lists are commonplace because there is a shortage of faculty. Incentives should be developed to encourage new graduates, as well as physicians and midlevel practitioners, to work in inner-city and rural areas. We especially need a new kind of paraprofessional in rural areas: sort of a "utility infielder" able to do EKGs, draw blood, and do simple lab tests. If we don't develop such pleuripotential personnel, the manpower shortages will continue to cripple our healthcare reform efforts.

It is time to put turf aside. The barriers that we have placed around para-professionals and physician extenders are going to have to come down. Unfortunately, some physicians have fiercely guarded their own territory because they misunderstand the importance of using nurse practitioners and physician assistants to expand the level of available care. Nursing territorialism concerning associate versus baccalaureate levels or vocational levels must be resolved in accordance with community needs, not just professional desires.

Consider the value of specially trained mid-level practitioners in geriatrics where they could extend the rural family physicians' role in long-term care facilities. Montana's Medical Assistance Facilities concept, was possible only when progressive legislation allowed physicians to maximize the use of such manpower sources. To be successful in Texas, a fair system must be developed for reimbursing physicians who use physician extenders; otherwise, physicians will not be able to hire them.

We could also explore the development of an innovative "joint venture" between primary care private physicians or National Health Services Corps assignees and the public health system. The effort would help provide needed public health interventions in rural areas, particularly where public health programs are either minimal or unavailable. State and local health departments could use these physicians on a parttime basis to provide some public health services in designated communities.

Such a program could allow primary care physicians to receive added compensation for providing services, thereby stabilizing their fiscal situation, and, at the time, provided a less costly alternative to the employment of potentially underemployed public health physicians.

The University of Texas School of Public Health, in Houston, and the Texas Department of Health could help train such physicians and provide formal examinations that award a "certificate of added competence" in public health. An analogous program in geriatrics is offered by the American Board of Internal Medicine and the American Academy of Family Physicians. Let's face it, this special approach is needed because few physicians are really trained in public health, much less environmental health or epidemiology. The Texas Department of Health has few Master's of Public Health as a percentage of employees than virtually any other health department in the nation. An innovative "in-between" and uniquely Texan solution could be tried, at least on a pilot basis, to meet our public health needs in rural and frontier areas.

This extra manpower on the front lines of health care would do a great deal to extend the health care safety net to include more patients.

Also by using the anticipated increase in numbers of National Health Service Corps physicians and paraprofessionals in innovative ways, we may be able to keep assignees in place longer. The proper models could even encourage them to convert to a private practice/public health model and become a more permanent part of the communities they serve.

In Dallas, we are doing this with our Community Oriented Primary Care program, which has developed a nonprofit physician's group practice. The ability of these physicians to link up to a system of definitive care has been an important key to recruitment and retention. The same can be done for an urban-rural system of care to provide not only transfer backup, but also continuing medical education, peer support and work relief.

This brings us to the need for serious statewide and regional health planning. Contrary to past beliefs in Texas, the mention of health planning and regionalization is not socialistic or worse.

We have a choice between the tyranny of urgency or a new pragmatism to wisely guide our stewardship of health care services for all Texans, urban and rural. We must do this for the well being of our patients and the betterment of our communities.

Ron J. Anderson, M.D., Dallas, President and Chief Executive Officer of Parkland Memorial Hospital, Dallas, Texas.

Congress (continued from page 9)

ance companies and businesses.

More than 25% of non-elderly Texans do not have health insurance; one in four. At the same time, 80% of uninsured Americans are workers with families. The strain placed upon our health care system by the uninsured is tremendous. In 1987, Texans provided $1.4 billion uncompensated or "free" care. Patchwork surgery to improve the system for the uninsured will not succeed.

The nation must develop a comprehensive national health care plan to meet the needs of the uninsured and our health care infrastructure. These changes would be profound and significantly alter our health care system; yet it clearly needs improvement. All Americans should be assured of affordable coverage of their appropriate health care costs, regardless of income, through private or government-financed insurance.

Access to health care for persons lacking insurance is a growing concern for all Americans and health professionals involved in our system. Three out of four Americans favor some form of a national health care program. Unfortunately, Americans are indecisive about their willingness

Special Articles

Is It Time for Universal Health Care in America?

Ron J Anderson MD

The time is rapidly approaching when we will have to decide how to rescue the sinking ship of health care in America. The safety net of our public hospitals is overflowing with patients from the 37 million uninsured Americans who have no other access to health care.[1] Furthermore, whether we recognize it or not, we all are headed for the same health-care lifeboat, and unless we ensure places for everyone, we will suffer individually and as a society.

The need for universal health care has been acknowledged by many groups. Several congressional commissions have studied the issue. The most recent, the Bi-Partisan Commission on Comprehensive Health Care—better known as the Pepper Commission—outlined an all-inclusive plan that would cover medical treatment, long-term care, and nursing-home care for all Americans. However, the Commission did not recommend a way to fund the estimated $66-70 billion cost.

A group called Physicians for a National Health Plan, the American College of Physicians, and other such bodies are on record as asking for a national health plan.[2] Recent surveys show that more than two thirds of Americans are dissatisfied with the cost and the access limits of the current system.[3]

In the absence of a new initiative, society's haves and have-nots are paying for a system that encourages the most expensive forms of resurrection medicine while containing costs by limiting health-care access to whole populations of people. In addition to paying for their own health care, the haves pay for the care of the poor *implicitly* through inflated hospital charges, spiraling insurance costs, and rising taxes. The have-nots pay *explicitly* for limited access with their health, their dignity, and even their lives.

The problems are hardly solved in existing programs for the poor, despite heroic efforts by some sectors. Many private nonprofit hospitals work with neighboring public hospitals and community health centers to form local networks of care for those who cannot pay. Nevertheless, demand almost always outstrips supply.

Although Medicaid was established as a state-operated program to finance health care to the poor, it covers only 24 million people—about half the total who need it. Two thirds of Medicaid's resources are consumed by the elderly and disabled, who comprise one third of Medicaid beneficiaries. The remainder are women and children who qualify as being poor.[4]

According to the Census Bureau, 75% of the 37 million individuals without health insurance are the working poor—either employed themselves or employed persons' dependents.[1] They don't receive health insurance through their employers, and they earn too much to qualify for Medicaid.

Because the reimbursement rate for services to Medicaid patients is notoriously low in many states, private physicians and hospitals often shun Medicaid recipients, not to mention the uninsured working poor. For example, studies done in the 1970s and 1980s show that 40% of obstetrician-gynecologists did not serve Medicaid patients.[5] As a result, these patients must go to the nearest public hospital, making a mockery of the *freedom-of-choice* concept promoted by physician lobbies.

Medicaid coverage and reimbursement vary by state, depending in part on each state's willingness to finance the options available through federal

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A version of this paper was presented by Dr Anderson as the Program Committee Special Lecture at the Annual Meeting of the American Association for Respiratory Care on December 10, 1990, in New Orleans, Louisiana.

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matching funds. Coverage ranges from penurious spending limits in some states to broad services and eligibility in others. Texas is among the worst states, covering only the poorest of the poor (approximately the lowest 20% of Texans live below the federal poverty level[6]). Medicaid reimburses my institution, Parkland Memorial Hospital in Dallas, for only about 45% of costs.

This inadequate and crazy-quilt approach not only delivers care to the poor haphazardly, but it unevenly distributes costs as well. Safety-net hospitals like Parkland respond to the bulk of health needs of the poor by providing uncompensated care. They additionally are being asked to serve as the health-care bulwark against infant mortality, teenage pregnancy, AIDS, crack cocaine, and violence-related injuries.

Nationally, the cost of unsponsored care (uncompensated care less appropriations from state and local governments) was $8.3 billion in 1988.[7] However, $2.2 billion of this cost was carried by only 57 of the nation's 6,780 hospitals.[8] These safety-net hospitals, therefore, comprise less than 1% of the nation's hospitals yet provide 27% of the uncompensated care, or an average of $38.5 million annually per hospital.

In Texas, approximately 80% of the uncompensated care is provided by seven of the state's largest urban public hospitals, including Parkland.[9] More than three million Texans live below the federal poverty line, which is an income of $12,675 for a family of four. They represent nearly 20% of the state's population; more than one third are children.[6]

In Dallas, approximately 350,000 residents live below the poverty level.[10] They are the primary users of Parkland, which serves as their family doctor and is the only public, tax-supported hospital in Dallas County. Approximately 70% of Parkland's patients qualify for charity care: More than 40,000 patients were admitted in 1989, and the outpatient clinics and emergency room handled a total of 582,700 patient visits.

Despite a neighborhood clinic system that provides prenatal care to 88% of the women who deliver at Parkland, a serious lack of prenatal care, particularly in the first and second trimesters, remains a major problem. Nearly 15,000 babies are delivered at Parkland each year, representing 42% of all births in Dallas County. Approximately 10% of the babies suffer low birthweights or are premature, requiring intensive care at a minimum cost of $1,500/day. Such problems are recurring themes at public hospitals across the nation, creating increasing health-care demands that serve as a negative barometer of the economy.

When the economy goes down, the demand for health care goes up, and public hospitals and public health-care systems take care of a disproportionate share of the indigent patients who have no other place to turn. It works until volume exceeds capacity; then quality of care is often sacrificed, along with the patient's dignity.

The strain on public hospitals' capacity is being exacerbated by the epidemics of AIDS, crack cocaine, and violence—and by the widespread prevalence of alcohol and drug abuse among pregnant women. Surveys of private and public hospitals say that at least 10-20% of pregnant women report using drugs or alcohol during their pregnancies.[11] The damage done by such abuse offsets gains made in improved prenatal care, to the point that we are losing ground in efforts to reduce low birthweight, infant morbidity (eg, congenital anomalies, learning disabilities, affective disorders, and withdrawal), and infant mortality.[12,13]

The heaviest burden of caring for indigent AIDS patients falls on the public sector. Of the nation's AIDS patients, 50% are treated in less than 5% of its hospitals, with the average revenue per patient visit being about 14% of the cost.[14] This pattern is also true for Parkland, which cares for approximately 60% of the AIDS patients in Dallas County. The nearly $10 million annual cost is largely unreimbursed.

Crack cocaine is the newest epidemic to strike our society, and it is remarkably associated with the spread of AIDS. Crack also is the primary factor in the rampant violence currently attacking major urban areas. Violent crime is at an all-time high in Dallas, where police reported a 24.7% increase in violent crimes for the first eight months of 1990, compared to the previous year.[15] The impact is reflected in the number of trauma cases treated at Parkland, which increased 30% in 1990.

With the surge in drug-induced violence, the associated need for trauma care is spilling over into those Dallas private hospitals that are voluntary members of the city's Emergency Medical System. These hospitals do not have to continue the

partnership and could withdraw their support. This has already happened in Houston, Los Angeles, Chicago, and Miami, where the lone public hospital in each community must deal with virtually all the city's trauma.[16]

But urban areas are far from alone in facing the difficulties of ensuring the availability of health care. The safety net of health care has all but disappeared in rural areas. Hospital closures and lack of obstetrical services are a problem in almost every state with a significant rural land mass and population.

In the decade of the 1980s, Texas led the nation in hospital closures, with 105 shut down; more than 60% of these were in rural areas. In 54 Texas counties there is no hospital at all; another 67 counties have only one hospital, which has less than 50 beds. Most of those remaining hospitals are not likely to survive through this decade. Of the state's 254 counties, 114 have no obstetrical services and offer only marginal pre-hospital care.[17]

Throughout the nation, doctors in small towns often cannot find dedicated and adequate transportation and inter-hospital care to transfer critically ill patients to urban hospitals capable of caring for them. They also encounter significant problems in getting urban hospitals to accept their non-paying patients. This is a critical health-care issue, considering that rural areas do not have the capability to handle trauma, neonatal intensive care, high-risk obstetrics, and other severe medical problems.

There is something desperately wrong in rural and urban areas alike. While millions of Americans do not have ready access to the system, some private hospitals are practicing boutique medicine, trying to earn a maximum profit while half their beds are empty.

This nation's health-care system is broken, because it is driven by utilization. American health insurance pays for the most expensive types of care and treatments, but it does almost nothing to encourage preventive medicine and health promotion. We can no longer afford this approach when hospitals cannot charge enough to cover their costs; when individuals as well as corporations cannot afford health-insurance premiums; and when insurance companies and the federal and state governments cannot and, I suspect, will not continue to finance fee-for-service, resurrection medicine in an open-ended, blank-check fashion. Already payer intermediaries second-guess nearly everything that providers do—in a manner as onerous as any government regulatory scheme. What's worse, despite the best efforts of the access-review firms, they still are not able to adequately control costs or ensure quality of care.

There Is a Better Way

We can create continuums of care that de-emphasize institutional care by addressing the well-being of patients. We need to create systems of health care that stress functionality as well as longevity in place of traditional medical-care systems, and we should fairly reward such new efforts. We are starting to do this for the underserved residents of Dallas through Parkland's Community Oriented Primary Care (COPC) program. The goal is to decongest the hospital's outpatient clinics and take health care into neighborhoods of high morbidity and mortality, where residents have not had access to primary-care services.

Parkland established COPC neighborhood health centers in 1989, and has already treated more than 90,000 patients. The centers focus on disease prevention and health education to reduce illness—and, consequently, to lessen future demand for costly secondary and tertiary care at Parkland. In 5 years, we hope to see 200,000 annual visits in such settings, at 60% of the cost of providing similar services at our 140-clinic, subspecialized facility at Parkland.

Preventive health measures work, as exemplified by prenatal care, which pays for itself many times over by reducing the need for neonatal intensive care. Indeed, the West Dallas pilot program that COPC is based upon decreased hospitalizations of children 75%, cut infant mortality 60%, and reduced teenage pregnancy 43% in less than a decade of operation. We also found that the cost of doing a better job is only a fraction of the previous cost, even before considering the contributions of improving the health status of a community and its members' productivity.

Parkland's experience shows that managed health care for indigent populations can be delivered efficiently and effectively through COPC programs. If funded by Medicaid on a larger scale, these programs would offer a vehicle that could allow sliding-scale purchase of primary medical care by the uninsured working poor.

The COPC model also could be easily adapted to rural areas. The program could create a lifeline

of care to underserved rural areas by linking them to referral networks with urban hospitals. Closed rural hospitals could be retooled and staffed to function as COPC health centers or Medical Assistance Facilities that render primary and emergency care and limited hospitalization before referring more critically ill or injured patients to urban hospitals via established networks.

Some system must be established before all existing capacity in rural communities dries up for good. To survive, the system must make good business sense for everyone involved, and it must create a win-win situation for both the urban and rural care providers.

One of the primary faults of our current system is that it isn't good business for our nation's economic vitality. That's why we are on the verge of a precipitous change in health care. As increasing numbers of American employers find that they cannot afford to buy health care for their employees, the overall health of the American worker will decline, resulting in our inability to compete in the world market. Additionally, the current high cost of health care is being passed on to purchasers of American products, thereby undermining our nation's competitive position in the global economy.

As a consequence of today's inadequate and costly health-care system, big business and big labor are calling for universal health care. Neither can afford to finance health care as it is practiced today, and they know that a healthy work force is essential to compete against countries whose infant mortality rates are a fraction of ours. Good public health creates healthier communities and a more productive work force.

It is through enlightened self-interest, then, that large corporations and unions already are concluding that universal health insurance is the way to address uncompensated care, control costs, and protect access. They are tired of shifting the costs. They want everyone to pay their share.

Workers who have health insurance as part of their benefits may have to pay more for elective coverage. If they want more than basic coverage, they should not be able to buy it with tax-exempt income as they currently do, unless as a society we are willing to provide similar coverage for citizens who require direct tax support.

Generous health-care benefits foster utilization, as does competition for the insured: The wealthier and healthier of our citizens. However, the overall cost could be minimized if we practiced medicine by emphasizing a universal program of health promotion, disease prevention, and public health.

We can always do better, and sometimes at lower cost. For example, we need better access to the value and contributions of new technology. We also need to assess more carefully the way we address certain clinical situations differently from location to location and from physician to physician; this could be done through better quality care reviews and through methodologies such as small-area analysis. All this should be done in the spirit of continuous quality improvement.

Costs most certainly would decrease if we were willing to recognize the interrelatedness of health care, education, economic opportunity, and decent housing. It is economically indefensible to continue to treat health problems related to poverty without also treating the root causes. By addressing the infrastructural issues of education, employment, and housing, society could transform many of its poor into taxpayers.

The fact that we have 37 million people without ready access to health care is an economic catastrophe for us all. We cannot become a more competitive country if we throw away whole populations of people. Neither can we enjoy internal tranquillity. Our most important resource is our population. In an information-driven, technological society, people will be either our greatest asset or a burgeoning albatross of homeless, unhealthy, uneducated, nonproductive citizenry.

This should plague our conscience as health-care professionals. Our concerted and individual efforts can make the difference in how communities and our nation address these problems. We must contribute to the debate and let our concerns and contributions serve as a lantern to guide those who make policy decisions.

Ethically, no matter what our station in life, we are of equal value. In the final analysis, we must recognize the universality of man in regard to disease and death and thus declare health care a basic right in this country. Once we make the ethical commitment and develop the political resolve, we will find the resources to provide universal, high quality, patient-valued health access for all our citizens.

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Guest editorial

COMMUNITY-RESPONSIVE MEDICINE: A CALL FOR A NEW ACADEMIC DISCIPLINE

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POOR ACCESS TO HEALTH CARE is one of the primary deficiencies of our modern medical system. Despite the fact that the U.S. Department of Health and Human Services (DHHS) has identified comprehensive health care to the indigent as one of this nation's priority health concerns,[1] access to health care has declined in this country in recent years, primarily as a result of the growing number of individuals—an estimated 37 million—without health insurance.[2] Equally large numbers of individuals, in particular women of childbearing age and children, are underinsured.[3]

Another indicator of access, ambulatory care visits, declined by 30 percent between 1982 and 1986.[4,5] The underutilization of ambulatory care placed even greater demands on public hospitals and emergency rooms as patients presented for treatment of preventable and episodic health problems. This pattern bypasses the most cost-effective and health-effective services which can be provided in a comprehensive primary care setting. Community-responsive health care minimizes fragmentation by reducing barriers such as transportation and by co-locating related services, such as laboratory; pharmacy; radiology; health education; Women, Infants, and Children (WIC) services; and immunizations, in one site. This concept of integrated care has been labelled "one-stop shopping."[6]

Community-responsive medicine can be considered the academic discipline of Community-Oriented Primary Care (COPC).[7] COPC is a way of practicing medicine that blends traditional primary care with public health

services. Primary care, a structural element of COPC, "can be defined as that array of health services provided by a practitioner to a patient that is accessible and acceptable to the patient, comprehensive in scope, coordinated and continuous over time, and for which the practitioner is accountable for the quality and potential effects of the services."[7] Primary care focuses on the individual patient or "user" and does not assume responsiblity for the health status of the community at large. In contrast, COPC is driven by the defined need for health services identified within the target community. By combining obstetrical, gynecological, pediatric, and adult medicine with public health services such as immunization and communicable disease control, COPC pro-actively aims to reduce the incidence of diseases that can lead to costly hospital care. COPC providers are accountable for results and take responsibility for the health status of a defined community. The community is empowered through education and involvement in the process to identify and rank its health problems.[7,8]

The COPC concept has had successful application in this country. The National Institute of Medicine reviewed seven case studies in a report published in 1983.[8] The case studies spanned both urban and rural practice settings as well as programs with academic affiliations. Not all of these systems had every aspect of COPC, but all had defined their target community and were providing directly or indirectly a wide array of related health services such as outreach, mental health, translation services, and immunizations. Two programs, one in Tucson, Arizona, and another in Oregon, prompted the revitalization of their respective departments of community medicine and fostered the expansion of the academic curriculum to include a community-based component.

In Dallas, Texas, Parkland Memorial Hospital has implemented a large COPC Program supported in part by county taxes. The program focuses health services to six at-risk communities in Dallas County that were identified in a county-wide needs assessment conducted by Parkland. The program is affiliated with the University of Texas Southwestern Medical School. Physicians working in these health centers are granted faculty status by the university and provide attending coverage on the inpatient units of Parkland Hospital. This arrangement enables the COPC Program to provide continuity of care for the practice and inpatient settings. The Program operates five health centers that handle in excess of 110,000 patient visits annually.

This effort to bring health care to the community and to be more responsive to its needs has resulted in significant improvements in the health of the community. Our data show that since 1968, when the predecessor to our program, the Children and Youth Project, began in West Dallas, emergency room admissions in the city have fallen, the incidence of teenage pregnancy in the Hispanic and African-American communities has dropped, and death rates for adolescents have been reduced.

The battlefield

Parkland Hospital's COPC Program is a local response to a national

problem. The health care industry is an immense machine. Driven by the provision of catastrophic and highly technological care, the industry consumes approximately 600 billion dollars per year, recording 100 million physician visits per year and 35 million hospitalizations. While expenditures per individual exceed $2,100 per year, the distribution of these resources is not equitable.[9,10] While efforts to control this runaway train have failed, critical measures of this nation's health status remain unconscionably unanswered. For example, during the 1980s alone, health care expenditures grew by approximately 120 percent, while black infant mortality remained twice that of whites.

In addition, the development and deployment of new medical technologies easily outpaced efforts made to assess their efficacy. Indeed, new and costly technologies are often approved for reimbursement under insurance plans prior to any rigorous evaluation of efficacy.[10,11] But during this same period, preventive health services were, as a whole, non-reimbursable. Individuals such as indigent minorities, who are at greatest risk of poor health outcomes and could most benefit from access to preventive and therapeutic primary care, remained disenfranchised. Their entry point into the health market is often through a crowded emergency room ill-equipped to deal with chronic medical conditions or to provide preventive health services. The relative, and at times absolute, lack of access to preventive health services for those at greatest risk has been described as "reverse targeting."[11]

These unmet needs for comprehensive access to health services were the driving forces behind the establishment of community-oriented primary care. Like the people it serves, community-responsive medicine rarely demands or receives conspicuous billing. As a result of its undistinguished heritage and lackluster economic performance, the discipline remains grossly understated, misunderstood, and unappreciated. The history of the assessment of community medicine by the medical profession sheds some light on its relatively low position in today's medical hierarchy.

Born in poverty

Community-responsive medicine traces its roots to health care for the poor. Ancient Rome created hospitals for the care of slaves, and European cities in the 13th century established hospitals for the poor. It was not until 1632, in Paris, that organized health services were developed for the poor in a non-hospital setting. This effort created what was known as the "Bureau d'Adresse," initially dispensing social services and subsequently medical advice. The founder of this center, physician Theophraste Renaudot, soon came under heavy criticism from the University of Paris, which believed his efforts were calculated to create a rival medical school. The University appointed an investigatory commission that denigrated the work of the dispensaries and labeled Dr. Renaudot a charlatan and sorcerer. A parliamentary court ordered that Dr. Renaudot's consultative services be terminated. Despite this setback, the court directed the Medical Faculty of Paris to set up "a system of charitable

consultations for the poor. . .within the week." This system was established in 1644. The concept of a system of dispensaries providing ambulatory care flourished throughout the 17th century and culminated in a decree by Louis XIV in 1707 that called for the creation of a dispensary by every medical faculty in the nation.[12,13]

A similar scenario occurred in England during the 17th century. The Royal College of Physicians promoted the idea of ambulatory services through the establishment of dispensaries in 1675. The effort met with similar opposition as the Society of Apothecaries cried "foul" and questioned the quality of pharmaceutical advice given by physicians in the dispensaries, which were providing care at lower cost to patients. An analysis of the confrontation revealed that the physicians were serving the poor who would otherwise seek "medical" attention at the apothecaries. As if a harbinger, economics played a pivotal role and ultimately prevailed when the physician-supported health services were abandoned.[12,15]

Dispensaries became a part of the American health care system in 1786, largely through the efforts of Dr. Benjamin Rush. Rush, one of four physicians to sign the Declaration of Independence, was among the first Americans to articulate the folly of a two-tiered system of care—one for the affluent and one for the poor. Additionally, he promoted the concept of ambulatory care as a cost-effective model and a place where "the sick may be relieved at much less expense to the public than in a hospital where provision, bedding, firewood, and nurses were required for accommodation." The first dispensary was established in Philadelphia and the concept grew and soon embraced the cities of New York and Baltimore.[10,12,15]

Dispensaries survived into the twentieth century in this country largely as a result of a need to provide clinical experience for medical students. This symbiosis would later be replaced by a more parasitic relationship between education and service delivery. Patients cared for in these settings were often perceived as teaching material. Caring for too many patients thus detracted from the educational experience. The conflict of missions between research, education, and patient care surfaced as a potential impediment to system reform, and direct competition between patient care and education for scarce and often fixed health dollars would become a consistent and more formidable force. During the early and mid-twentieth century, the role of dispensaries was gradually subsumed by large outpatient departments in urban hospitals in order to provide a more convenient setting for faculty and specialty clinics. Without an increase in overall financial support, dollars that had once gone for the provision of patient care were now consumed in salaries and administrative overhead for the teaching institution.[16-18]

Today, health care is highly influenced by special interests. Indeed, the health care industry is analogous in some ways to the military/industrial complex, an amorphous and entangled public/private-sector venture which employs hundreds of thousands of individuals across the country. Both entities are large in terms of expenditures and payroll, vital to local economies, export-

able, fueled by a drive for new technology, and worthy of political attention. But placing priorities on technological achievement and economic profitability, and in efforts designed to support our affinity for "resurrection medicine,"[20] not only denies resources to others in need, but frustrates the will to create a system of care capable of reducing fragmentation, duplication, and access barriers. Disjointed programs force individuals at risk, or who are sick, to make choices and trade-off one service for another. This approach has created a "system of missed opportunities,"[20] whereby, for example, a woman seeking a pregnancy test at one clinic is not enrolled on the same day to enter prenatal care or family planning. Instead, she is told to return in six weeks to another clinic at another site for services. The odds increase against her returning until late in her pregnancy or at the first pains of labor.

In addition, the trend in health policy is to create a new program for every new health problem. This "disease of the month" approach can circumvent important issues and problems. The more different, the less attractive, or the less vocal patients are, compared to the mainstream, the more likely are they to be left out. With the creation of new legislation comes the justification for more regulations, more guidance, more bureaucrats to administer the programs, more powerful agencies, more grant writers, and more auditors. Unfortunately, this growth in infrastructure also breeds more confusion among providers, payors, bureaucrats, and patients, and more non-productive turf battles as agencies, bureaus, universities, and clinics scramble to compete for limited resources.[20]

Competition for funding and prestige often finds community medicine drawing the short straw. Federal programs which have historically supported the development of community-responsive medicine, such as the National Health Service Corps, the Community and Migrant Health Program, and primary-care training grants from the Bureau of Health Professions, have struggled to remain at "level" funding. When appropriation levels during the 1980s are controlled for inflation, the National Health Service Corps and the Bureau of Health Professions realized a dramatic cut in funding while the Community and Migrant Health Centers scrambled to keep pace with inflation, this at a time when overall health care expenditures for the nation increased by approximately 120 percent.[18]

The role of academia

Academia has played at times a disruptive role in the history of community-responsive medicine. Just as the University of Paris impeded the efforts of Dr. Renaudot, today academia often confers the title of "LMD" (Local Medical Doctor) or worse on physicians who practice in such settings.[12,21] How many students have heard a professor of medicine, surgery, or obstetrics question the desire (if not sanity) of students or residents to provide primary care in a community setting? There has been and continues to be a sharp demarcation between "town" and "gown" physicians, a demarcation that exists, in part,

because of the relatively low value placed upon community-based primary care curricula in both undergraduate and graduate medical education, and the specter of inferior medicine being practiced in these settings.[21]

Academic medicine comprises two competing and contentious siblings: research and medical education. On many medical campuses, a rather clear-cut hierarchy dictates that education remains secondary and subservient to research, and service delivery is subservient to education. Primary care and community medicine are searching for their rightful place in this hierarchy. It is a hierarchy dictated by the corporate bureaucracy of medical education, which to a substantial degree determines medical curricula. In tune with the adage, "He (or she) who has the gold, rules," grants for research and reimbursement for high-technology tertiary care define the power brokers in academia. Loss leaders and less profitable departments such as primary care, community medicine, and outpatient areas are frequently not able to sit at the head table of academic decision makers.

Similarly, curriculum committees are influenced by the departments which can afford to pay the salaries of the most residents and research fellows. The expectation is that a body will be available to that department for service needs throughout the year. This has resulted in curricula dominated by rotations in intensive care and procedure-oriented subspecialty departments that are equally well-endowed and reimbursed. Meanwhile, rotations designed to introduce young physicians to comprehensive primary care or community-responsive medicine are sacrificed or may be offered as unattractive electives.[21,22,24] Undergraduate medical education has placed a similar high premium on the traditional hospital-based curriculum and avoids such disciplines as epidemiology, prevention, and public health.[21-24,27]

One outcome of the current method for establishing medical curriculum might have been forecast in 1988 with the failure of a large number of family practice programs to fill their residency positions. Programs in pediatrics and internal medicine experienced a similar downswing in applicants and an upswing in unfilled residency positions in 1989. There is growing concern that this nation may not have enough primary care physicians to meet the needs of our aging population, or the complex primary care demands created by the HIV epidemic and substance abuse.[21,22,24-27] In 1963, primary care physicians represented 49.2 percent of all practicing physicians, while today they represent less than 35 percent of all practicing physicians.[21] The ratio of primary care physicians to the overall population has remained essentially unchanged since 1963 when the figure was approximately six primary care physicians per 10,000 population. To place these numbers in perspective, the United States has a much smaller ratio of primary care physicians to population than does Canada or Western Europe.[24,25,27,28] In Canada there are approximately 11 primary care practitioners per 10,000 population, representing 68 percent of all physicians in that country.[22,23,25,26]

Our pattern of rapid growth in subspecialty medicine has revived the debate as to whether or not there is an oversupply of physicians. Current

prognosticators suggest that there indeed may be a shortfall of primary care physicians, which is accelerating as increasing numbers of pediatricians and internists turn to subspecialization.[24-27]

Thus, the academic culture is neither creating nor encouraging the development of effective role models in community-oriented medicine. Individuals commited to community medicine and public health are often perceived as eccentrics who exist in spite of the system and are merely in search of an institution that will grant them tenure. These humanistic and competent clinicians may be shifted to non-tenure clinical tracks because of their perceived failure in the basic sciences. This trend accelerated during the 1970s and early 1980s with the privatization and corporatization of medicine and medical education.

Zero-sum financing

Because of the reality of fixed resources, the rivalry between research and health care delivery often results in an "either/or" funding ultimatum. The modus operandi for health financing in the 1980s was to assume that there is a fixed pie of available health dollars, and that research and health care delivery must compete for it. This mechanism of financing and reimbursement pits one program against another, offers few rewards for collaboration and integration, and further fragments health services and their support networks in research and education. The result is a fractured, flawed delivery "system" which forces a mother with finite mobility and time to decide between seeking care for her sick child at a well-baby clinic, to the exclusion of going across town to visit a WIC office, uptown for immunizations, and downtown for post-partum care.

The outcome of such zero-sum competition for limited resources has the additional unfortunate effect of "robbing Peter to pay Paul." It ignores potential savings that can be realized by avoiding illness and repudiates the belief that improved health status is interrelated with education and economic opportunity.

Community-oriented primary care seeks to remedy the flaws in this disjointed, fragmented system by first understanding the needs of the community, and second by providing these and related services in one location within the community. The leadership and committed corps of health professionals needed to implement this program must be nurtured and supported by a new experiential academic discipline, community-responsive medicine, which embraces the concept of COPC and moves the academic medical classroom into the community.

Conclusion

The need for an effective response to this nation's health care deficiencies has never been more apparent, and never more desperate. The reluctance of the health care industry and the medical profession to embrace systemic change or

to address academia's competitive priorities, community medicine's underclass status, policy makers' infatuation with "diseases of the month," and needless competition for fixed assets have placed this nation in the tenuous position of failing to meet the health care needs of many of its constituents. This nation and its leadership have ventured into an abyss of responding to isolated and narrowly defined health problems with narrowly focused resources.

Community-responsive care is well positioned to respond to this challenge. Medicine responsive to the needs of the community reflects an attempt to move beyond the current maze of disjointed programs which fail to capture and maintain individuals in a comprehensive care system. The concept of "one-stop shopping," recently promoted by the United States Public Health Service to describe a model of prenatal care for this country, is also an appropriate model for health care in general.

The success of community-responsive medicine will demand the preparation of physicians and other health professionals who can recognize the evolving needs of society and respond with effective preventive and therapeutic measures. It will require health care providers who can function beyond the limits of categorical programs, and face head-on the sexually active teenager who is homeless, out of school, alcohol-abusive, and at risk for AIDS.

To address the conflict between patient care and education that often appears in academic settings, it may be beneficial to remove community health from the academic arena, where it has resided intermittently, and recognize the strengths of both while acknowledging their fundamentally different missions. Financial incentives to maintain both components would have to be developed and maintained, and be non-competitive. An even more appropriate response would be to build on mutual strengths, and to challenge academia to produce physicians capable of responding to the health needs of a community. Critical to this response will be a commitment to attract and develop effective primary care role models.

The federal government, too, must lead. Federal support—one barometer of national health priorities—for service delivery has grown only sparingly over the last ten years, while dollars for research have expanded substantially. Similarly, aside from the growth in Medicaid expenditures, the majority of which still go toward catastrophic and long-term care, federal DHHS expenditures for primary care service delivery show negligible growth in the past decade after correction for inflation.[18] The federal government must recognize the contributions of small programs such as the National Health Service Corps, Area Health Education Centers, and of grants to primary care training programs in general internal medicine, pediatrics, and family practice. The National Health Service Corps in particular has been successful in providing a "curriculum" for community-responsive care where academia has been unwilling or unable to do so. These experiences must be maintained, augmented, and brought into the mainstream of professional education.

Our search for a health care system grounded in a comprehensive response to community needs will require innovation, reform, and changes—

changes in financing, reimbursement, policy, and medical education. It will require change from the dominance of structure over ideology, innovation through the disruption of the influence of special interests, and reform as this nation discovers both the will and the way. This nation has a vested interest in the health of its citizens as we speed toward the twenty-first century with an aging population, a potential shortfall in our labor force, and the next public health crisis which will test our system of care.

Today, community medicine as a primary care discipline may be on vastly unequal footing with such giants as inpatient care, medical education, or research. Yet history suggests that its quest for acceptance is in good company. Like the efforts of Drs. Harvey, Jenner, Pasteur, and Lister, community medicine has endured opposition, neglect, and scorn. Whether the field will yet emerge as an accepted alternative to current practice, as did the work of these earlier pioneers, will be the test of our national resolve to reform.

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PREPARED STATEMENT OF REPRESENTATIVE MIKE ANDREWS

Mr. Chairman, thank you for the opportunity to testify today about health care reform. As a leader in the health reform debate, you know first hand the complexity of this issue.

My colleagues, Congressmen Jim Cooper and Charlie Stenholm, and I have proposed a solution that is not lacking in complexity. It is easy to say: "I'm for the Canadian system." But unfortunately, there are no easy answers.

The proposal under consideration in the House of Representatives to put price controls on all providers is simply a step in the direction of a single payer system. It turns the insurance industry into a regulated utility and removes the spirit of innovation from the health care system.

But Americans are crying out for a solution. Polls show that 70 percent of the public want radical change.

The reason is obvious: America's health care system has stopped working. It does not work for the woman who gets breast cancer and can't switch jobs because the insurance company won't cover the treatments. It does not work for the small business that can't afford to cover its employees. It does not work because the cost of health care keeps going up.

Medical costs have doubled since 1980. The price of premiums paid by businesses has tripled. Thirty-seven million Americans do not have health insurance. The American people are demanding action, but are not comfortable with the proposals made so far.

Other Democratic proposals try to fix the problems by having the government run the health care system. The Administration's proposal does not do enough to control costs.

We are calling for a new approach to health care reform. It is called managed competition. We owe a great debt to the Jackson Hole Group led by Dr. Paul Ellwood and Alain Enthoven for developing these ideas.

Right now, insurance companies compete on avoiding bad risks. We want insurers to succeed when they manage risk.

Right now, hospitals and physicians can bill insurance companies regardless of how good they are. We want providers to be accountable for their results.

We want to create a market where consumers can shop for health care and health insurance as a single product. Americans should be able to buy health care based on cost and quality like any other consumer product.

We want to bond together the insurance companies and providers. Physicians, hospitals, and insurers should make more money when people are healthy, not when they are sick.

Under our plan, health care providers will have an incentive to find and use less expensive procedures because their bottom line will be the same as the insurer. Both will want to provide effective health care at the lowest cost.

The system we have now allows too many hospitals to provide the whole range of specialized care. For example, a study in California determined that one-third of

the hospitals doing coronary bypass operations failed to meet the volume standard set by the American College of Surgeons. At a lower volume, physicians do not have enough experience to be effective. The result has been a higher mortality rate in these low-volume hospitals.

Many of those patients would have lived had they gone to centers of excellence with high volume like the Texas Medical Center. Under our proposal, they would have lived because providers will be organized more efficiently and effectively.

The tax code also encourages wasteful health spending. For every extra dollar businesses spend on health care, only 69 cents comes out of their pocket. The other 31 cents comes from the government. This government subsidy encourages inefficiency.

The most abusive example is a health plan with first-dollar coverage. This means that the business pays for every health care expense including the deductibles and copayments. This arrangement takes away the incentive for consumers to use the health care system prudently.

Our proposal limits the tax deduction for businesses to the cost of the least expensive insurance plan. Businesses can buy more expensive plans, but they will not receive a taxpayer subsidy.

If we will eliminate first-dollar coverage plans, we also add an incentive for people to stay healthy. Americans must take more responsibility for their health.

Prevention is the key to controlling health care costs for the individual. We will ensure 100 percent immunization levels for children. We will give flu vaccines to older Americans. And we will require health insurance plans to have no deductibles or copayments for preventive care.

It is incredible that our health care system does not measure quality. We rarely collect data on whether a patient gets better or not. We need to know when the health care is working. Under our bill, providers will be required to disclose their performance in a public report.

We are not getting our money's worth from health care. Economics teaches us that if supply increases, then prices should fall. The supply of hospitals and physicians has been growing rapidly since the 1960s. Yet, health care costs have risen steadily over that time. The cost of health care has risen from 9 percent of the gross national product in 1980 to nearly 14 percent today. Clearly, the market isn't working.

The market will work if we arm consumers with information about the cost and quality of health care. We need to get value for our money.

Not everyone will be able to afford health insurance even once we control costs. The average American family without health insurance has an income less than $20,000. The average uninsured adult works for a small business with fewer than 25 employees.

Our plan targets these families. Small businesses will pay lower premiums because they will have the benefit of group rates through health insurance purchasing cooperatives. Our plan will guarantee health coverage to 40 percent of the uninsured in Texas, offering financial assistance to an additional 30 percent who are between 100 and 200 percent of poverty.

Our plan is the only comprehensive health reform bill that can be enacted this year. It does not call for price controls, which the Administration strongly opposes. It greatly expands access to health care, which Democrats strongly support. It is a plan that will make the health care system work once again.

PREPARED STATEMENT OF E. RICHARD BROWN

I am Richard Brown, professor of public health at the UCLA School of Public Health. I have conducted many studies of health insurance coverage and access to health care, and I have been very involved in the development of public policy proposals to address the crisis of the uninsured and rising health care costs. Thank you for inviting me to testify about proposed reforms of our health care financing system.

Literally nine out of ten people in the United States believe that we must reform or rebuild our fragmented, unequal and costly scheme of private medical insurance, public program coverage, and lack of any coverage. The dilemma is, of course, what should we do with it? Should we enact President Bush's proposed package of tax credits and tax deductions for middle- and upper-income persons, vouchers for the poor, and some small-group market reforms, making only modest changes in the current voluntary private health insurance arrangement? Should we reform the system by requiring employment-based coverage through a "play or pay" mandate? Or

should we transform the system into a universal national health insurance program?

I would like to respond to this dilemma by laying out the goals that I believe health care financing reform should achieve to resolve our systemic problems. I will then describe the two fundamental reforms that will achieve these goals. These reforms are the core of national health insurance, but several alternative models embrace these necessary changes, including one model that I will specifically discuss.

GOALS OF REFORM

It is widely agreed that our health care system suffers from many ills—chronic conditions of spiraling costs, inadequate coverage, and insufficient effectiveness. Everyone agrees that these virulent problems are disabling our health system, and many fear that they are fatal. The measures of these ills are both their absolute magnitude and their severity relative to other industrialized countries.

A close examination of the comparative performance of our health system confirms what a few brief points will convey: the costs, coverage and effectiveness of the United States's health care system compares unfavorably with the systems in most other industrialized countries. The United States has the most expensive health care system in the world: this year we will spend a 50 percent greater share of our GNP on health care than any other country in the world, 40 percent more dollars per person on health care than the second most expensive country. These excess economic resources going to health care add to the labor costs of American products and services, diminishing our international competitiveness and imposing a heavy absolute burden on business and on workers. Despite these extraordinary expenditures, we are the only industrialized nation that leaves one-quarter of its population with inadequate medical coverage or without any coverage at all. Perhaps most important, health indicators of the American people compares unfavorably with those of many nations that spend much less on medical care than we do. At least 21 other countries have lower infant mortality rates than ours, and our children have embarrassingly low rates of immunization against preventable illnesses. And these expenditures do not even buy happiness: compared to other industrialized democracies, Americans are among the least satisfied with their health care system.

Health care reform must provide coverage for those who have none, but it must do more than shift people from the ranks of the uninsured to the insured. In my opinion health care reforms should accomplish five goals:

(1) cover the entire population for comprehensive health benefits,
(2) create a system that provides equitable access to quality care,
(3) make the financing of health services more equitable,
(4) control health care costs effectively and fairly, and
(5) obtain more value for the resources we devote to health care.

There are two fundamental reforms that I believe will accomplish all five of these goals. First, we should replace private payments for health insurance premiums with a program that, like the Medicare hospital insurance program, is tax funded. Second, we should reform the way we pay providers in order to control health care costs effectively and fairly. Other changes may be desirable, but these two fundamental changes in our health care financing system, while politically difficult, are essential to create the foundations of a financially sound, fair and effective health care system.

REFORM 1: REPLACE PRIVATE PAYMENTS FOR HEALTH INSURANCE WITH TAX-FUNDED PROGRAM

The enormous benefits of shifting from private health insurance to tax-funding greatly outweigh any political liabilities.

Tax funding will untie health insurance coverage from employment

Perhaps the most important benefit is that a universal tax-funded system will cut the link between employment and health insurance coverage. Compared to proposals that keep health insurance based on employment, uncoupling it from employment will:

- **create a universal financing system to cover everyone for full benefits.** Being in a program that serves the entire population is the best protection for low-income groups and the elderly who otherwise would depend on separate public programs. Only in a universal program, through which the middle and upper classes get their care, can lower-income workers and the poor avoid isolation in a program that is politically vulnerable to the budgetary axe. This is

their fate today, as it would be in other reforms that create a public program only for those not fortunate enough to be covered by an employer who "plays."

- **free employer from the administrative burdens of providing health benefit.** Negotiating or running medical benefit plans is a significant cost to any employer and especially to small firms. Separating coverage from employment will enable employers do what they do best—run their businesses.
- **eliminate disruptions in coverage and changes in health plans and physicians when enrollees become divorced or widowed, disabled or retired, unemployed or change jobs.** These are real concerns of people now covered by job-based health benefits, and only reforms that make coverage independent of employment would eliminate these disruptions.
- **give all people more choice among private health plans, doctors and hospitals.** When coverage is separated from employment, people can choose any health plan or doctor, rather than selecting from an employer's offering of one or very few plans.

Tax funding for health care is fairer

Tax funding also is a fairer way to finance health services than insurance premiums and heavy cost sharing. Private insurance premiums, including employment—based benefits, are regressive because their flat dollar charges fall disproportionately on people with lower earnings and profits. Financing with tax revenues is more equitable because:

- **tax contributions of worry and the self-employed are at least proportional to earnings.** Tax rates automatically adjust what people pay to their incomes rather than requiring a separate, often humiliating and expensive administrative process to decide who gets subsidies under a premium-based system.
- **tax contributions of employer are proportional to labor costs,** an advantage for many businesses that pay low wages and have low profit margins. Because these conditions generally characterize new businesses, adopting a tax-funded system rather than one that requires employers to buy health insurance will facilitate an important engine in our economy. A tax-based financing system can also reduce or eliminate the need for a separate subsidy program for employers.

Tax funding, as opposed to our present private payment of insurance premiums, will separate coverage from employment, and it will be fairer.

REFORM 2: CONTROL COSTS BY REFORMING PROVIDER PAYMENT

The second fundamental reform that we desperately need is to change the way we pay providers. There are at least two somewhat different models to what is commonly called national health insurance, but both involve restructuring payment to doctors, hospitals, and health plans. Cost control is very effective under a universal tax-funded system of national health insurance, in large part because governmental monopoly over health care payments gives government both the need and the means to control provider payments. In addition, administrative expenses are much lower because there is less paperwork.

Under the Canadian model of national health insurance, the government program is responsible for paying providers directly for the population's health services. This model of paying providers appears to be far more effective than our current system in controlling costs and ensuring access to quality care, although there is some dispute among health economists about just how effective it is relative to our own. Clearly, this model has succeeded, where ours has failed, to keep increases in health spending in line with increases in the GNP, to protect families against increases in medical costs, and to provide sufficient access to quality care to make Canada's population the most satisfied with its health care system among the major industrialized countries.

The model represented by Senator Kerrey's Health USA bill and similar proposals adapts some of the best features of Canadian and European health care financing systems to the best foundations of the United States's own delivery system. This model relies on private doctors, hospitals, and other providers to deliver care, and it gives the public increased choice among private and public health plans that organize the delivery of care. It combines the efficiency and equity of a tax-funded financing system with the effective cost controls of an all-payer system in paying private providers and health plans. This model controls costs through budgeting and financial incentives on health plans, as well as on providers and patients.

The Health USA model

Under Senator Kerrey's Health USA proposal, the federal program will pay state-administered programs an average of 87 percent of the cost of caring for the state's population; the states pay the balance. Each individual or family may enroll in any health plan approved by the state program, including many private plans or a plan run by the state program. The state program will pay approved plans a capitation payment for every person enrolled, making the plans responsible for providing or arranging care for their enrollees. Through the approved plan of their choice, enrollees will receive covered services and obtain their care from participating physicians and other professional practitioners, hospitals and other facilities.

Under Health USA, the plans will pay professional providers either fees, as part of an all-payer system of fee schedules and expenditure targets, or capitation payments or salary. Physicians and their appropriate practitioner associations, with whom they share a common interest in preventing costs from escalating, will receive practice profiles to help them keep within their overall expenditure target. Hospitals will be paid for each admission, based on a negotiated annual budget, and will be paid their marginal costs for additional services above budget targets. (This approach avoids penalizing hospitals that serve larger-than-expected volumes of patients but also does not provide incentives for hospitals to aggressively market services.)

This specifically American payment system emphasizes cost-containment methods that influence provider behavior, a strategy that encourages providers to use resources more wisely. This general approach to paying providers has proved successful in Europe, Canada, and repaid health plans in the U.S., and it has been adopted in principle by the U.S. Medicare program. Because physicians and hospitals generate the overwhelming share of medical costs, they are in the best position to control costs. Putting health plans at financial risk for all required benefits for the specified capitation payment (plus allowed copayments) gives them incentives to control costs, while the provider reimbursement systems gives them effective methods to do so.

The only alternative to budgeting the system and deliberately shaping provider behavior through financial incentives is to increase the use of utilization controls and patient cost sharing. Utilization controls, by trying to directly regulate doctors' behavior, necessarily intrude into physicians' clinical decision making and undermine professional autonomy. Increasing reliance on patient cost sharing deprives the less affluent of needed care, a cost-control method that is inequitable and not good for the public health. Senator Kerrey's proposal minimizes the need for these methods.

The "managed competition" strategy's method to control spending relies heavily on cost sharing for health plan premiums as well as for medical care. Employers and families shop for less expensive plans, and plans compete by bargaining with providers for discount reimbursement rates. This strategy forces patients to choose a cheaper, lower quality health plan if they cannot afford to pay the added costs of better plans. Enrollees in basic private plans and any public program will be stuck in a lower tier with less access to quality care, while the more affluent population and their employers will find themselves shelling out growing sums of money for the care they need. The all-payer system in Health USA, on the other hand, forces health plans to compete for patients on the basis of their quality and services, bringing everyone into one equitable financing system while enabling everyone to choose the health plan that offers them the type of care they want and need. Yet, it controls costs at every level of the health care system.

These two fundamental reforms—replacing private payments for health insurance premiums with a tax-funded program and restructuring how we pay providers—will create a solid foundation from which our health care system can develop into one that offers more value for the dollars we spend. Whether we consider these reforms as a package that we call national health insurance or as separate elements of comprehensive reform, they are both necessary to cure what ails our health care system. Whichever specific models are included under these broader reforms, they will give everyone greater choice of providers. They will reduce out-of-pocket costs that most people pay when they need to see a doctor. And they will end the ever increasing drain on employers, workers and our economy.

National health insurance is the standard against to which to judge other proposals to reform our health care financing system. I think you will agree that other approaches do not measure up to the universal coverage, accessibility, extensive choice, and cost controls of either of these specific models of national health insurance.

Thank you for considering to my testimony.

PREPARED STATEMENT OF STUART BUTLER

Thank you, Mr Chairman, for the opportunity to testify today on ways in which market-based reforms can achieve the goal of universal, affordable health care in America. I would emphasize that I testify in a personal capacity, and my comments should not be construed as representing any official position of The Heritage Foundation.

I would like to break my comments into three parts. First, I will discuss how we have the worst of all worlds today -- a "market" for health care rendered dysfunctional by perverse incentives emanating from the tax code. In my view this corrupted market is the root cause of the inflation and uninsurance problem in health care. Without the reform of the incentives, we cannot achieve our goals of affordable access.

Second, I will discuss how a reformed market could be constructed and how it would work. In particular, I will discuss how consumers would make choices in such a system, and how this would lead to cost control.

And third, I will review some of the bills now before Congress that seek to achieve market-based reforms.

WHY TODAY'S HEALTH "MARKET" DOES NOT WORK

The vast majority of working Americans obtain their health care services through a medical plan offered through their place of work. The value of these plans is excluded from the worker's taxable income. Moreover, even though the cost of the plan is part of an employee's total compensation, that employee is not in a position to choose an alternative plan to that offered by the employer -- unless he or she is prepared to lose substantive tax benefits -- and the employee's use of health services has no direct impact on the cost of his or her plan. Therein lies the problem.

In this system, the prices of most services are subsumed within an insurance package, the price of which is set according to the experience rating of a company-based group. The specifics of each package are determined by the employer (or through negotiation between the employer and organized employees), and between the employer and providers (directly or though an insurer as intermediary). In addition to the cross-subsidy from low-risk to high-risk employees implicit in the group rating approach, there is an additional cross-subsidy from general taxpayers to covered employees by virtue of the tax exclusion available for company-provided plans.

It should be noted that this system came about more or less by accident. The Canadian and British systems, by contrast, were designed and created after an intense national debate. This did not happen in the U.S. When cash wages in the U.S. were controlled during World War II, expanding fringe benefits became a way for employers to attract scarce labor. Rulings by the Internal Revenue Service after the war firmly established the tax-free status of such benefits. These policy decisions were not taken to create a health system for working Americans, but to deal with much more limited issues.

This system does avoid many of the drawbacks of an unfettered market for health care. While prices do function within the system, they influence choices made by providers, insurers and third-party payers rather than by the consumers of health services. Thus price does not pose an unacceptable barrier to reasonable access for most covered consumers (although limits on coverage, copayments and deductibles eventually can amount to a financial barrier). Consumer confusion regarding the choice of plan, and in many instances even the selection of a provider, is avoided by the employer taking on this responsibility.

Yet the problem with this system is that it is still driven in large measure by consumers reacting to price at the point of consumption -- it is just that the prices encountered by the consumer bear little or no relation to cost. This absence of real prices for the consumer, either for specific services or for a health package, leads to an economic dynamic that makes cost control and the goal of universal access such perplexing problems in today's health care system. Hence the calls for radical reform.

The Side-Effects of the System

Effect #1: Inflation. In this system, consumers make what are for them quite rational economic decisions, yet they do not face directly the full economic consequences of their decisions. In particular, they have the incentive to overdemand services that are underpriced or "free" to them. Even though the heavy use of services means that the cost of their insurance premiums rise, they have little incentive to consider that. One reason is that with premiums set according to the group's aggregate demand, one individual sees little connection between his use of services and the premium. Another reason is that the employer is seen as paying the premium -- even though labor economists would point out that cash wages and fringe benefits combine to form a total, market-determined compensation package, and thus are "paid for" by the employee.

Effect #2: Opposition to cost-controls. The tax treatment of benefits, moreover, leads to an understandable resistance among employees to attempts by employers to encourage workers to control their health costs by introducing copayments and similar financial devices to raise cost-consciousness. Company-provided plans are tax exempt, while out-of-pocket payments with rare exceptions are not. Thus the employee has the perverse incentive to prefer a package with no out-of-pocket element over a medically identical package including a copayment with a lower total cost.

Effect #3: Competition by over-supplying services. Among the other consequences of this distorted market is the incentive for providers of services to compete for patients on the basis of available services, rather than on benefit compared with cost. Thus an expensive "arms race" occurs in the medical sector, in which hospitals and physicians entice customers with increasingly sophisticated but costly equipment and procedures. Third party payers respond by questioning in detail the treatments agreed by physician and patient, to the irritation of both.

Effect #4: Gaps in Insurance. In addition, the tax treatment of health care is a significant contributor to the huge gaps of coverage in the U.S. system. Families with company-provided plans receive financial assistance through the tax exclusion, while most individuals without such coverage receive no such tax help. Moreover, the most tax assistance goes to employees in the highest tax bracket with the most generous plans. Meanwhile workers without company plans must pay in after-tax dollars for insurance, and face prices for services that are driven up by the rational but inefficient decisions of consumers insulated by company-paid plans. Many such workers and their families respond to the effects of this inequitable tax treatment by not buying insurance. In fact, approximately three-quarters of the uninsured are employed individuals or the dependents of workers.

The Response of Congress

The response of many policy makers to this unsatisfactory and increasingly unpopular system is to propose alternatives that try to move even further away from a traditional consumer-driven market. One proposed alternative is a government-financed single payer system, based on the Canadian or British models. Another is to try to deal with the gaps in coverage by requiring employers to furnish employees and their families with a minimum level of benefits or contribute to a public program to deliver similar benefits to uninsured workers and their families.

Problems of single-payer systems. The single-payer approach would eliminate consumer choice entirely as a device to achieve economic efficiency and cost control. Instead it would substitute a system of allocation based on fixed budgets and government-administered fees to providers. In such a system, officials must use "objective" methods to determine value and benefit, in contrast to the subjective consumer determination in a normal market. Whatever the virtues might be of such an approach, the world's experience with price and budget controls -- in health care or the entire economy -- is that controls must become ever more pervasive and elaborate, shortages and explicit rationing become a permanent feature of the system, and measurements of value become more arbitrary and contentious.

Problems of employer-mandates. Mandates on employers do not establish a total budget for health care, nor in their basic form do they change the incentives facing the consumer. Thus mandates pose problems as a discipline for demand-induced treatment cost escalation and as a method for controlling total health costs. Most mandate proposals try to address this by including very complicated mechanisms intended to guide consumer choices and avoid cost shifting. Some versions would introduce into the private sector the fee-setting features of a government-sponsored single-payer system.

The assumption behind each of these alternatives is, of course, that consumer choice is of little use as a tool for cost control or resource allocation in health care. Yet it is possible to imagine a very different system of health care in the U.S. that would be based on consumer choice, rather than seeing it as irrelevant or a problem. Under this arrangement, cost control at the macro level is achieved by changing the environment in which microeconomic decisions are made by consumers of health care.

CREATING A CONSUMER-BASED SYSTEM

Creating a consumer-based health care system would involve several important elements. Among them:

1) Consumers must have a wide choice of plans.

The key to cost control with efficiency in a market system is for consumers able to choose between competing producers on the basis of undistorted prices. This does not happen today because the tax system discourages American from choosing a plan offered by anyone other than their employer. Ending the discrimination in the tax code in favor of insurance at the place of work largely would permit families to choose a plan sponsored by an organization other than their employers. For instance, a family might choose a plan offered through a union, or a church, or a farm bureau. The important thing is that the tax code should not penalize the family from making a sensible decision on the basis of value for money.

In addition, providing the same tax relief for out-of-pocket expenses as for insurance premiums would induce many consumers to accept higher copayments and deductibles in order to reduce premium prices -- thereby encouraging patients to question the prices of providers.

Incentives for consumers: If the tax code were more neutral in this way, the costs and benefits of health packages would be compared without the perverse incentive to choose an expensive one merely because it was provided through an employer. Choosing between health plans is not, it should be noted, the same thing as choosing between individual physicians or hospital services on the basis of prices. But it would lead indirectly to a similar result. In a tax-neutral market for health plans, consumers would be invited to consider trade-offs. One plan -- such as those still common today in older, unionized companies -- might fully reimburse virtually all services and place few limits on choices of physician or hospital. Such a plan would be expensive compared with another that also placed few curbs on physician choices but imposed a significant copayment. It would likely be even more expensive than a managed care plan with tight limits on the consumer's choices once they enter the health care system.

Incentives for plan organizers: Consider such a situation. If the consumer has a free choice of plan, without any tax bias in favor of one or the other, the consumer's sensitivity to the price of each package will tend to lead to efficient cost controls within each package competing for the consumer's dollars. In a managed care plan, the consumer in effect chooses to accept limits on his choices once receiving care in return for a less costly but satisfactory package of services. But to remain competitive, the plan must provide overall satisfaction compared with alternatives, and so plan managers must strive for the best combination of plan price and the quality of service by their chosen providers. Similarly, a plan allowing greater choice of physician and course of treatment must introduce reasonable and efficient price incentives to encourage the patient to economize if its premium price is to be competitive.

Thus even though the consumer may not directly question the quality and price offered by each provider, his ability to choose between plans means that plan managers are driven by the consumer's reaction to the overall price he is offered to assemble a package of providers, services and incentives for the patient that curbs costs and promotes efficiency.

The analogy with auto purchases: As an analogy to this process under which individual physician and hospital charges and quality are indirectly determined by the consumer, consider the purchase of a car. When a typical American buys a car, he does not and would not want to negotiate with a carburetor manufacturer, a tire company, an upholsterer and so forth to assemble his car. He buys a package, and rival companies compete in offering him a package. Each company knows that what matters to the consumer is the overall performance and price of the package, and perhaps some specific features. Constantly influenced by the consumer's likely reaction to combinations of quality and price in the assembled car, knowledgeable companies engage in a detailed examination of the price and quality of components offered by competing suppliers. Thus although the buyer of the car does not directly question the cost and quality of each element in the package, he does so indirectly through the car company competing for his business. A patient, in effect, would have exactly the same influence on providers in a market with competition between health plans and consumers with the incentive to compare cost and overall quality.

Similarity to the FEHBP: This essentially is the way in which the Federal Employee Health Benefits Program (FEHBP) operates, and why it is able to keep its cost increases one-third below that of the private sector. Federal employees are free to choose between a wide array of plans, with the premium and out-of-pocket cost made explicit and the same method of government assistance no matter which plan they choose. Because these plans must compete, plan managers have to take steps to keep service costs under control without sacrificing quality.

2) Consumers need to be subsidized.

A simple open market for medical care and services means consumers who required a heavy volume of medical services would in many instances face prohibitively high medical bills or insurance premiums. Thus a market-based health system does require them to be cross-subsidization.

Today's employment-group system relies on equal premiums for different individual risks as a principal method of cross-subsidy. As insurers and corporate benefits manager know all too well, this system is very vulnerable to healthier members of the group "escaping" to other health plans priced more in line with their lower risk. But an alternative method of cross-subsidization would be to allow consumers the freedom to choose between alternative plans priced according to plan and the buyer's health risk, and then to subsidize the buyer directly so that he could reasonably afford the premium. An example of such a method of cross-subsidization would be a sliding-scale tax credit to offset premium and out-of-pocket health costs, with a voucher or refundable credit for those paying little or no taxes. In this arrangement, the percentage credit would be determined by the individual's total anticipated outlays on premiums and direct health

costs compared with his income; the higher that ratio the higher the percentage credit.

Subsidizing through the tax code rather than through equal premiums would avoid most of the problems associated adverse selection. In fact, "adverse selection" -- considered a problem in health care -- is the equivalent of "consumer choice" in other sectors -- normally considered a virtue of the market system and the key to efficiency and cost control. Changing the method of cross-subsidization would make it a virtue in health care.

3) Consumer ignorance has to be addressed.

An efficient market requires consumers to make well-informed decisions, and on the face of it this might seem difficult to achieve in a consumer-driven market for health care. For one thing, "user-friendly" information is in short supply for patients in today's U.S. system (as it is, of course, in the government-run systems in Canada and Britain), and even with such information it would be difficult for many if not most Americans to make confident choices.

Why consumer information would emerge: The lack of usable consumer information today, however, is the result of the weak incentives for rational consumer choice rather than some inherent imperfection in health care markets. When a system provides little incentive for consumers to compare quality and price -- and even more important a strong tax disincentive against choosing any alternative to a company-sponsored plan -- it is hardly surprising that there is a dearth of information on which a consumer can determine good value for money. Significantly, in the Federal Employee Health Benefit system there is abundant information in various forms. Besides official government handbooks, a detailed comparative guide to competing plans, giving such information average likely expenditures under each plan for various categories of family, is published by the Center for the Study of Services, a Washington area consumers' organization. In addition, Washington's talk shows and newspapers are full of discussion about rival plans during the period in which plans can be chosen. With consumer choice a feature of the entire U.S. system, there is every reason to expect similar information to be demanded and supplied throughout the country.

Similarly, corporate buyers facing mounting health benefits costs increasingly are demanding information on quality and outcome from providers, and using this information to chose providers for their plans. With the consumer an active ingredient in the system, rather than a passive observer as he is today, the managers of health plans would have a strong incentive to make such information available to consumers or to consumer organizations, rather than as today only to corporate benefits managers.

Helping consumers choose -- the role of non-employment groups: Consumers unable to digest even user-friendly insurance or medical information would do what consumers do in similar situations when they are unfamiliar with a product or service -- rely on a trusted professional or agent. Primary care physicians and insurance brokers are obvious examples of experts who are routinely turned to assist with complex medical or insurance decisions.
In addition, a likely development under the consumer model outlined would be the emergence

of new groups acting as organizers or brokers of plans. The current tax treatment of consumer health purchases encourages only employer-sponsored plans. But under the tax treatment outlined, other organizations would be natural candidates to organize health plans. Some of these, as today, would be provider-based, such as health maintenance organizations. Others would be groups with the characteristics of a "friendly society." Unions would be an obvious sponsoring groups, since members of the union could reasonably expect the union to act wisely on their behalf. In fact, union-organized plans are a feature of the federal employee system, attracting non-members as well as members. Other possible groups would include farm bureaus (some of which already organize plans), alumni associations, churches and groups representing those suffering from particular chronic illnesses, such as diabetes. In the latter case, the plans no doubt would feature a particular set of specialized services needed by group members. Besides acting as reliable agents for consumers, such groups would provide many of the benefits normally associated with insurance groups today. As bulk purchasers, for instance, they would be able to negotiate with providers and insurers, and offer lower marketing and administrative costs in exchange for discounts.

The consumer could in addition be assured of a certain range of basic services within each plan by government regulation. As a legal condition of sale, a comprehensive health plans could be required to contain certain features, such as catastrophic stop-loss protection. In addition, consumers could be required by law to purchase a plan with at least this basic package of features, to assure all families were adequately covered.

ASSESSING THE PROPOSALS

Several proposals have been forward to introduce market mechanisms in varying degrees into the health care system.

1) The Heritage Consumer Choice Health Plan

A market-based proposal has been developed by myself and Edmund Haislmaier. It would exchange the current exclusion in a revenue neutral manner for a system of refundable credits, and it would require all non-retiree families to purchase a basic health plan, with credits available against premiums and the cost of supplementary medical services.

The Heritage Consumer Choice Health Plan also would make important changes to the way health insurance functions. In effect, the proposed reforms would create true insurance, with risk carried over time by the insurer, in place of today's "insurance" -- which is in large part simply an annual charge to pay for a group's anticipated health costs that year.

The details of the Heritage proposal are contained in an supplement to this prepared testimony.

2) The President's Plan

President Bush's proposal has some features in common with the Heritage proposal, but differs in some fundamental ways.

By offering a health voucher to the poor, and tax deductibility for non-employer sponsored plans for the currently uninsured, the President's proposal is a major step toward creating a market-based health system in America. Americans currently uninsured would receive financial help, through the tax system or through a voucher, to obtain a health plan. They would have the right to choose a plan from any licensed source, such a union or directly from an insurer, with the same form of government assistance whichever plan they chose. Further, they would have the incentive to pick the plan with what they considered the best value for money. Thus the President's plan would introduce the main features and dynamics of a consumer-based system.

The chief limitation of he President's proposal is that while it would help the uninsured, and give these American the incentive to choose wisely, it would do very little to change the incentives or to open up new plan choices for Americans currently insured at the pace of work. Thus it would have much less impact on cost control than the more comprehensive Heritage proposal.

3) (S.2095) The Affordable Health Insurance Tax Act (Symms)

The Symms bill would introduce a tax credit for a portion of the cost of a health plan purchased by a family. As such it would move in the direction of the Heritage proposal by granting tax relief for plans other than those obtained through an employer.

The Symms bill also contains the interesting innovation of a tax-shielded medical savings account, designed to encourage Americans to shoulder directly a larger share of their medical costs and thereby to seek better value for money in health costs and insurance.

Again, the Heritage plan is more comprehensive and it is budget neutral. The medisave account is compatible with the Heritage proposal, although most of the purposes of the account would be served by the equal tax treatment of insurance and out-of-pocket costs under the Heritage plan.

4) (S. 1936) The Health Equity and Access Improvement Act (Chafee)

The Chafee bill introduces, among other things, a new refundable credit for health care purchases for low-income families. It makes other tax reforms, such as raising the health tax deduction for the self-employed to 100 percent, and it offers various tax credits to small businesses to help them provide insurance to employees.

The Chafee bill also is an important step forward. Unfortunately it chooses a complicated solution over a simple one. Rather than introducing one comprehensive tax credit, allowing all Americans to choose from a wide range of plans beyond those offered by the employer, the Chafee approach introduces a number of specialized credits and deductions to maintain the employment-based system that is in part the chief deficiency of the current US health system.

Several other bills also contain tax credits or other tax incentives to permit families to offset the cost of obtaining insurance if it is not available through the place of work, such as S.314 (Cohen).

A group of other bills, and some provisions of certain bills already mentioned, seeks also to make the "supply side" of the insurance market operate more competitively by reforms to require insurance to be made available to small firms -- sometimes called small group market reforms. These measures could be beneficial in alleviating some of the worst symptoms of the current crisis (such as the lack of affordable insurance for employees of small firms), Unfortunately, the bills do not tackle the underlying drawbacks of system based almost exclusively on employment, such as the perverse tax incentives and the cost advantage enjoyed by large employer groups. They simply deal with one side-effect.

If Congress were to adopt a comprehensive tax reform approach, which would allow employees of small firms to join alternative groups, the small market reforms would become unnecessary. The appropriate insurance reforms in that environment would be to require insurers to accept high risk individuals at a reasonable premiums and to renew policies at the choice of the customer. In other words, reforms to accommodate individuals choosing their own group, rather than steps based on the assumption that many Americans must remain in artificial, small groups based on employment.

Mr. Chairman, I understand that Congress is receiving little clear guidance from the American people as to how they want the health care system improved -- even though Americans are clamoring for reform. I understand also that in such a political environment the incentive for Congress is to make relatively modest changes. But in my view these will have a negligible effect on the system, and will only increase public frustration. Fundamental reform is needed, and reform based on two related foundations, that assure public satisfaction and economic efficiency -- individual choice and a consumer-driven market.

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A POLICY MAKER'S GUIDE TO THE HEALTH CARE CRISIS PART I: THE DEBATE OVER REFORM

By Stuart M. Butler, Ph.D.

INTRODUCTION

The United States health care system has come under increasing criticism in recent years and is fast becoming a central issue in this year's national election. The reason: although the U.S. system has obvious virtues, there is widespread dissatisfaction with the system among ordinary Americans.

For most of these Americans, the quality of care is not the central problem. Indeed, the quality of the U.S. system is the envy of the world. People flock to America when they want the best—even people from Canada, despite its vaunted national health system. And Americans rarely go abroad for health care.

The chief concern of Americans, surveys show, is with the way in which health benefit plans are organized and financed. They worry about losing benefits when they change jobs or joining the ranks of the uninsured when they are laid off. They fret about being wiped out financially by a disease that is not covered by their plan or whose cost exceeds their coverage limits. They complain about the seemingly endless paperwork associated with even a minor insurance claim. And if they are employers, they are frustrated at their lack of success in trying to hold down exploding health benefits costs.

Fundamental Reform Sought. Various bills before Congress, as well as proposals under discussion around the country and a plan unveiled recently by the Bush Administration, seek fundamental reform of the U.S. health care system. Some would replace it entirely with a government-run system like that of Britain or Canada. Others would require all employers to provide at least a basic package for all their workers and their families, or pay a tax to fund government-organized health benefits for those without company insurance.

Others still, including a proposal from The Heritage Foundation, suggest a different approach. These proposals start from the premise that the health system is in such bad shape because the tax and regulatory treatment of health plans has distorted the health system in such a perverse manner that anything resembling a normal market has broken down. What these proposals would do is change the rules so that consumers would have the incentive and the means to choose the

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health plan they want, and the ability to afford at least a basic plan.

Under the Heritage Foundation Consumer Choice Plan, which will be discussed in Part II of this *Talking Points* series, the current tax break for employer-provided health benefits would be replaced with a tax credit for health plans or medical services obtained from any licensed source, not only an employer.[1] Like the other major approaches being debated, this relatively simple change would have profound effects on the health care system.

This *Talking Points* Part I examines the reasons for the concern about health care. It then summarizes and analyzes the major options for reform.

WHAT'S WRONG WITH THE U.S. HEALTH CARE SYSTEM?

The first thing to understand is that the U.S. health system actually is several systems. There are **government-operated systems**, such as the Veterans' Health Administration, in which hospitals are owned by the government and doctors are government employees. These are much like the core of the British National Health Service.

Then there are **government financed and regulated** systems—chiefly Medicare and Medicaid. According to the Congressional Budget Office, Medicare covers about 27 million elderly Americans (another 3 million disabled individuals also are covered) and Medicaid provides primary coverage for about 15 million non-elderly Americans. In these programs the government pays private doctors and hospitals set fees to treat certain individuals. These function much like the Canadian system.

Then, for the vast majority of working Americans, there is a system of **employer-sponsored private health insurance.** About 150 million Americans under the age of 65 are covered in these company plans.

Q. What is driving the calls for major reform?

A. While there are concerns about every sector in this system, the political debate today centers on the private insurance system. While most Americans do not fault the quality of the health care they receive from employer-provided health plans, they grumble loudly about other features. Among them: they can lose coverage or have worse coverage if they change jobs; employers always seem to want to cut benefits or make the employee pay more for coverage; mountains of paperwork accompany every claim.

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1 See Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); Stuart M. Butler, "Using Tax Credits to Create an Affordable Health System," Heritage Foundation *Backgrounder* No. 777, July 20, 1990; Stuart M. Butler, "A Tax Reform Strategy to Deal With the Uninsured," *The Journal of the American Medical Association*, Volume 265, May 15, 1991.

Q. So why do most Americans have company-provided plans?

A. It is a historical accident driven by two connected events. First, when wage controls were instituted during World War II, firms encountering severe labor shortages increasingly expanded fringe benefits, especially health benefits, to attract workers. Second, the Internal Revenue Service ruled after the war that such health benefits would, without limit, be free of federal income and Social Security tax. These events, not any national consensus that employers are the best people to organize health benefits, brought about the system that determines the health care available to most Americans.

Q. How does the tax law encourage employer-based plans?

A. Under current law, if a worker accepts a health package from his or her employer, the insurance element of that package is tax-free.[2] Any out-of-pocket payments by the employee (such as deductibles or items not included in the plan) are not tax-free and must be paid for in after-tax dollars.[3] If the employer does not provide insurance or the employee prefers some other plan, the employee gets no tax break for buying insurance or medical services himself.

Q. Why does this tax treatment cause problems?

A. The employment-based system artificially encouraged by the tax code leads directly to the problems commonly cited by Americans as the reasons why fundamental reform is needed. Among them:

Problem #1: If you change your job, you must change your health coverage; if you lose your job, you lose your coverage.

Because health insurance for most families is employment-based, when a worker changes or loses jobs, suddenly the family's health coverage changes or is lost. If the new employer provides insurance, it can mean a major change in benefits. Sometimes families lose benefits they like; often they will have to switch to a new doctor that is included in the new plan. Often a change of job can mean financial disaster. Even if coverage is available from the new employer, usually there are "pre-existing condition" clauses in the plan, meaning the family will not be covered for an existing illness. And if

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2 Including cases where the employer "self-insures," that is, carries the insurance risk himself, and cases where the insurance takes the form of monthly payments to a pre-paid managed health plan, such as a Health Maintenance Organization (HMO). For self-employed individuals, only 25 percent of the cost of a plan is tax-free.

3 There are certain exceptions, the main one being a deduction available under Schedule A of the tax form (itemized deductions) for out-of-pocket costs that exceed 7 1/2 percent of adjusted gross income.

the new employer does not offer insurance, or the worker becomes unemployed, the family must gamble with its health or buy its own coverage—without a tax break.

This is why so many of the 34 million Americans who are uninsured at some time during a year actually are workers—sometimes well-paid workers—or the dependents of workers. In fact, about 80 percent of uninsured Americans are workers or the dependents of working Americans.

Q. But is this problem really due to employment-based insurance?

A. Yes. This so-called portability problem does not occur with other major forms of insurance or major household expenditures. When a worker changes jobs he does not suddenly lose his life insurance and have to take a medical examination and apply at perhaps higher life insurance rates—or be turned down as a bad risk. He does not lose his car insurance. Nor does he have to refinance his mortgage. The reason is that these important items are portable because they have nothing to do with employment. And more important, the beneficial tax treatment of, say, life insurance or mortgage interest has nothing to do with employment. Only a family's health insurance availability and tax treatment depends on the bread winner's place of employment.

To understand the absurdity of today's tax treatment of health care, imagine a different America. In this America, the only way to receive a tax break on life insurance payouts or whole life insurance investments is to have insurance provided by an employer. And suppose, by contrast, a tax break is available for health plans whatever their source. The newspapers then would be full of heart-rending stories about families losing life insurance when they changed jobs, of widows left penniless when an older worker was laid off and could not afford a new policy because of a heart condition. But there would be no stories in such an America about workers losing health benefits when they changed jobs, because that would not affect health insurance.

Problem #2: If you work for a small firm, you are more likely to lack insurance.

Like other forms of insurance, the cost of health insurance generally is less when people are covered in a large group. Among the reasons: individual risks can be spread by the insurer across the group and so there is a smaller "risk premium" charged for a large group policy; paperwork costs associated with premium collections and marketing are smaller. This is why buying insurance through an organization (such as an automobile club or some other membership group) normally is cheaper. With employment-based health insurance, this means that the firm with 3,000 employees generally can get a much better rate than a firm with three employees. Worse still, the small firm can find its premium costs skyrocketing if it hires a fourth employee who has a large family or a checkered medical history. The reason: the cost of one high-risk employee cannot be spread widely.

The high cost of health insurance for small groups is why small employers are much less likely to provide health benefits and thus why so many uninsured Americans work for these firms. Some 43 percent of uninsured workers are employed by firms with 25 or fewer workers. It is also why all attempts to encourage wider employment-based insurance run into an enormous problem—how to make insurance affordable for small firms.

The fact that an individual works for a small firm, of course, does not affect the cost of his life insurance, his homeowner's insurance, or his auto insurance. This is because the premiums are not based on employment groups. To be sure, an employee of a small firm could join a large group to obtain the economies of scale and risk-spreading to reduce rates—perhaps a health insurance plan organized by a union, his church, the state farm bureau, or even an automobile club. This does not happen because there would be no tax relief for plans obtained through these non-employment groups.

Problem #3: If you are well-paid, you get a large tax break for health coverage. If you are low-paid, you get little or nothing.

The tax-free fringe benefit status of company-based plans is much like a normal tax deduction (except that there is also relief from Social Security taxes). This means that the higher the tax bracket of the employee, and the more generous the health plan, the larger the tax break. This "tax exclusion" was worth $66.6 billion in 1991 in federal taxes avoided, and another $8.3 billion in relief from state taxes.[4]

But according to Lewin/ICF, a Washington, D.C.-based econometrics firm specializing in health spending analysis, nearly 26 percent of this tax relief goes to households with incomes in excess of $75,000 per year, and just over 6 percent to households earning below $20,000. At the federal level, a household earning $100,000 or more has a tax break worth an average of $1,463 each year. A working family earning under $10,000 gets an average of $50 in tax help. If the family has no health plan (far more common for low-paid workers than high-paid workers), there is no tax break at all.[5]

What this means is that the revenue cost of the tax exclusion is heavily skewed towards upper-income earners. This in turn means the government gives little or no help to those working Americans who find it hardest to afford medical care. The system is great for Chrysler chief Lee Iacocca, but terrible for the part-time janitor at a local Chrysler dealership.

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4 The relief from federal income tax was $39.7 billion. The relief from Social Security (including Medicare) taxes was $26.9 billion.

5 Estimates prepared for The Heritage Foundation by Lewin/ICF, January 15, 1992.

Problem #4: The employer-based system encourages overinsurance, higher paperwork costs, and higher premiums.

The tax treatment of company-based insurance means that a $10 headache prescription or a $30 routine teeth cleaning covered by an insurance plan is tax-free while a $5 bottle of Tylenol or a $1 box of dental floss is not. Consequently, workers and unions press for even the most routine items to be included in health insurance plans. This means that company-provided health plans often "insure" workers and their families against completely predictable minor health costs. And every time a small cost is incurred, forms have to be filled out and processed, adding to the cost of the health plan. But this costly system of overinsurance is quite rational for the employee, even though it means high premium costs (which ultimately come out of his total compensation, of course) because it means these routine, minor costs are tax-free.

Workers would never insure themselves in this way for other aspects of their daily life, such as automobile care. Americans understand well that if they were to "insure" themselves against the cost of an oil change, new tires, tune ups, or even (to complete the analogy with routine health care) the cost of the weekly gasoline fill-up, the price of the extra insurance would far exceed the cost of paying for the items themselves. That is also the case for health insurance, according to a study by the Dallas-based National Center for Policy Analysis. Nevertheless, workers press their employers to overinsure them for health care because insurance is tax-free and because they live under the illusion that company benefits somehow are free.

Problem #5: It is extremely difficult for employers to hold down costs.

In any normal major retail purchase, say of a life insurance policy, or a car, or a house, there is a buyer and a seller. The buyer pays the seller and is the one who consumes the product or service. There may be expert intermediaries involved (a broker or a real estate agent, for instance), but they represent one of the sides in the transaction.

In employment-provided health insurance the buyer-seller relationship is very different because a third party (the employer) enters the picture. The employer is not the consumer of health services yet he buys the coverage and pays the hospital or doctor (directly, if the employer self-insures, or indirectly if the employer buys health insurance).

This third party arrangement leads to a very different relationship between the consumer (the patient) and the seller (the doctor or hospital) in health care transactions. For the patient, it means the cost of a service usually is of little or no concern, since the bill will be sent to the employer.

To be sure, as labor economists point out, the cost of company health coverage is part of the employee's total compensation package and thus ultimately comes out of the worker's pay, just as the "employer's share" of So-

cial Security taxes does. But the employee sees little or no direct relationship between the cost of a particular treatment and the size of his paycheck. Thus, there is little or no incentive to economize. Similarly there is no reason for the doctor to mention cost when suggesting a test or procedure to the patient.

To understand what this means for costs, imagine if companies "insured" their workers for the cost of buying and repairing the family car. Families would have little reason to bargain with a dealer — why would they accept a stripped-down car when they could have one loaded with options and "paid for" by their company? And car mechanics would do very well. A squeak under the hood? Why not have the repair shop take the engine apart? Or better still, why not put in a new engine? After all, the company is paying.

In company-based health insurance, then, the patient and doctor are concerned about benefits, but not costs. Meanwhile, the company is concerned about costs, but not benefits. This is a recipe for two things: rapidly rising costs and friction between employees who do not want to lose benefits and employers who want to cut costs. Employer health care costs are surging. They rose 21.6 percent in 1990 and 12.1 percent in 1991. The rate in 1991 was about four times the general rate of inflation. But as employers fiercely resist these efforts. According to the AFL-CIO, about three-fourths of strikes today center on health benefits.

THE REFORM OPTIONS

There are three principal ways to reform the health care system for working Americans (leaving aside reform of Medicaid, Medicare, and other health programs). Each of them places somebody in firm control of how many health care dollars are spent and who gets what services. Each has profound implications for the economy and the health care of American families.

Option One: This first plan is known as **"Play or Pay."** This actually would build on the current employer-based system while expanding Medicaid. In this system employers and the government would make the major decisions regarding what services Americans will receive and how much will be spent.

Option Two: The second plan recognizes that employer-based insurance is the heart of the problem. Known as the **"Single-payer"** or **"Canadian"** approach, this would substitute the government for employers, with the government paying for health care out of taxes and paying doctors and hospitals according to fees negotiated between providers and the only legal buyer—the government. The government also would set total spending levels for health care in America.

Option Three: The third plan, known as the **"Consumer Choice"** model, also recognizes the flaws of the employment-based system. But instead of letting the government take over, it would give consumers the ability to make the major decision in health care spending. It would do this by changing the tax treatment of health purchases to enable families to purchase their own plans.

HOW THE PLAY OR PAY APPROACH WOULD WORK

Under this approach, employers would be given a choice: provide at least a basic comprehensive health package for workers and their families or pay a payroll tax to fund coverage under a public program, similar to Medicaid. The main bill before Congress based on play or pay (S. 1227) is sponsored by Senate Majority Leader George Mitchell, the Maine Democrat.

This legislation would mean universal coverage. But it would have serious side effects. Among them:

Side Effect #1: Half of all working-age Americans would be dumped into a super-Medicaid program. When faced with a choice between providing a health plan and paying a tax, many employers would opt to end coverage and simply dump their workers into the public program. With the 7 percent payroll tax proposed as the basis for the Mitchell bill, the Washington, D.C.-based Urban Institute estimates that 51.7 million workers would lose their employer-sponsored coverage (one-third of workers who now have company plans).[6] This would mean 112 million Americans would be in a Medicaid-type program.

Side Effect #2: Americans would face huge tax hikes. If the public program were to be as large as reliable estimates suggest, high payroll or income taxes would be needed to support it. The Urban Institute estimates that with a 7 percent payroll tax, the public program would be underfunded to the tune of $36.4 billion per year. Even raising the payroll tax to 9 percent would only shave that shortfall to $25.2 billion. This would leave the government with three choices: 1) operate the system in the red, with the red ink adding tens of billions of dollars to the deficit; 2) raise taxes generally, slowing growth and cutting after-tax incomes; or 3) hike payroll taxes well beyond the level envisioned by the bill's sponsors. But any increase in payroll taxes is a tax on employment and means fewer jobs, especially for the lower-paid.

Side Effect #3: Insurance costs would soar. The cost of health coverage for employers would rise under the Mitchell bill. With a minimum benefits package in the Mitchell bill, the Urban Institute estimates that the extra cost to employers of providing insurance (or paying the tax) would rise by $29.7 billion, or 23 percent. For large firms, this means an average hike in health costs of 21 percent, and a 71 percent rise for firms with fewer than 25 employees. Moreover, if minimum benefits were mandated by Congress, unions would have the incentive to lobby Congress for across-the-board increases in basic benefits, rather than negotiating with individual firms.

6 For an analysis of the Mitchell bill, see Edmund F. Haislmaier, "The Mitchell HealthAmerica Act: A Bait and Switch for American Workers," Heritage Foundation *Issue Bulletin* No. 170, January 17, 1992.

Similarly, medical groups would lobby for certain procedures to be included in the mandatory benefits package (as they have done successfully at the state level). These pressures could increase insurance costs dramatically, leading to more and more workers being shifted into the public program.

Side Effect #4: Small employers would face new hardships. The Mitchell bill does give small firms several years to comply with the play or pay requirement, and it includes various complex tax benefits to offset some of the high cost of small-group insurance and it would delay the mandate to play or pay for four years. But even these breaks add to the complexity of a supposedly simple approach and merely give a four-year breathing space.

Q. Is play or pay an example of "bait and switch"?

A. While purporting to be a simple extension of the current system, play or pay almost certainly would evolve into the government-run system publicly eschewed by its supporters. It baits and then switches.

Reason #1: Employers increasingly would have the incentive to pay rather than play, for the reasons indicated above.

Reason #2: The Mitchell legislation includes draconian anti-discrimination measures against any employer providing insurance who appears to use health condition as a reason not to hire or to lay off an individual (a natural response by employers if they are required by law to cover all families). Faced with the prospect of costly civil rights suits if they provide insurance, it is likely that more and more employers would choose the public option.

Reason #3: Play or pay proposals, including the Mitchell bill, set up all the apparatus needed to introduce a Canadian or British national health system. This includes boards to negotiate fees and set overall budgets—the central feature of the Canadian system. The legislation is replete with references to these boards being "advisory" or offering "recommendations" but few Washington insiders doubt that the board's decisions soon would be mandatory. Thus Americans might vote for comprehensive employer-provided benefits, but eventually they would find themselves in a super-Medicaid program.

Q. Will Congress suffer from the bait and switch?

A. Absolutely not. Once again, Congress exempts itself. The Mitchell bill would not apply to Congress, the executive and judicial branches, or federal workers.

HOW THE SINGLE-PAYER APPROACH WOULD WORK

The second approach reasons that private markets in health care simply do not work, and that in this one part of the economy the government can do a better job than the private sector. The model used is Canada. By using the government as the central buyer of health care, allocating resources, negotiating fees with physicians and hospitals and cutting out insurance middlemen, advocates of a Canadian-style system for America insist that overhead costs can be slashed, costs kept down, and quality improved. This best of all possible worlds turns out to be snake oil. Among the reasons:

Reason #1: Canada is very different from America.

While the Canadian system satisfies Canadians, it probably would not satisfy Americans or even work in the context of U.S. institutions. For instance:

- **The political culture is different.** Canadians, like Britons, put a premium on equality, and accept the long waiting lines that come with a system based on rationing (see below). Americans likely would not.

- **The political institutions are different.** Canada's parliamentary system, with its strong parties, is much less prone to special interest lobbying than the U.S. Congress. That makes it easier for the Canadian government to place strong constraints on doctors and hospitals—and patients. A Canadian system in America also likely would lead to the detailed micro-management by Congress that is seen in Medicare and the Veterans' health program.

Reason #2: There would have to be explicit rationing.

When the government sets an overall budget for health spending, but then declares that care is "free" to all citizens, heavy demand and limited supply lead inevitably to shortage and rationing. This is routine in Canada.

Q. Couldn't there be rationing in the U.S.?

A. No. Under the Canadian system, rationing takes two main forms. First, hospital and other budgets are set by government. And second, doctors routinely make rationing decisions every day--not to save a very premature baby, not to admit immediately a patient with mild chest pains, not to order a CAT scan on a crash victim with a headache. Doctors can do this in Canada because they do not work under the malpractice system facing American doctors. U.S. doctors would find themselves in court if they made rationing decisions like their Canadian counterparts. This means that the doctor-rationing process that is key to the Canadian system would be impossible in the U.S.

To make rationing work, two things would have to occur. First, Congress or the states would have to gut the medical liability laws—no easy political task in face of severe opposition from the trial lawyers and "public interest" groups. Or

second, Congress would have to legislate detailed priority lists for treatments and make no funds available for low-priority treatments—in effect, forcing doctors to ration. The political problem with this, as Oregon is discovering as it tries to introduce priority lists for Medicaid, is that Americans get very angry when treatment for *their* condition is at the bottom of the list. Trying to set national priority lists would be a nightmare for Congress, and would invite constant modification based on lobbying by patient groups and provider organizations.

Reason #3: The vaunted overhead savings of the Canadian system are highly suspect.

Supporters of the Canadian system say that billions of dollars could be cut out of the overhead in the U.S. system simply by replacing insurance companies with a government monopoly. The argument is that monopoly is efficient in health care competition inefficient. To be sure, there are indeed great inefficiencies in the U.S. health insurance system, but these are due to perverse consumer incentives and not to deficiencies of competitive markets.

Supporters of the Canadian system tell only half the story. Any health system, like any business, can reduce overhead by eliminating procedures to make sure that resources are used wisely, staff are acting efficiently with an eye on cost, and inventory is kept at economical levels. It can institute budget limits so that the cash simply runs out when too many procedures are performed. But this does not lead to efficiency. On the contrary. In the U.S. health system an enormous amount of paperwork is devoted in health care, as in other parts of the economy, to make sure that health resources are used as efficiently as possible. This certainly generates paperwork but it promotes efficiency and reduces the cost to the economy of keeping patients away from work.

In Canada there are few if any such procedures to promote efficiency. Thus inefficiency is rife in the health system, with hospitals occasionally shutting down for want of key resources, long waiting lists for certain procedures, and outdated equipment in many hospitals. Moreover, when Canadians are waiting for treatment and unable to work, this imposes costs on the Canadian economy.

Reason #4: The Canadian system may be more expensive, not cheaper, than the U.S. system.

Supporters of the Canadian system point to the lower percentage of gross national product spent on health care as proof that the Canadian system is better at controlling costs. But various studies explode this myth.

- **Trend's the same.** If there were savings achieved in the Canadian system, they were made before the system became a national health plan in 1971. Ever since the mid-1970s, however, the rate of increase in costs in Canada has been virtually identical to that in the U.S.

- **Creative accounting cuts costs.** The Canadian system appears less costly because Canadia does not include many of the costs in its health spending data that the U.S. does. Example: the construction costs of hospitals are

not fully included in Canada's health care spending statistics, while in the U.S. they are. Example: the costs of treating doctors and other health workers are not fully included. If the Canadians employed the same accounting methodology as the U.S., says Jacques Krazny of the international accounting firm of Bogart, Delafield, Ferrier, Inc., based in New Jersey, Canadian health costs would rise by at least 1 percent of GNP.

☞ **Demographic differences.** The Canadian system is not treating the same kind of population. These lifestyle and demographic differences account for cost and quality differences. For example, the teenage pregnancy rate in the U.S. is two-and-a-half times that of Canada and U.S. drug use is higher. This leads to a higher proportion of low birthweight babies. The U.S. population also is older than Canada's. Such differences impose higher costs on the U.S. system, and also explain many of the apparent quality differences suggested by crude infant mortality rates and other national data. There is, moreover, a simple "bottom line" about quality in the U.S. and Canada. It is this: Canadians fly to U.S. when they want the best treatment. Americans do not fly to Canada.

Reason #5: A Canadian system in the U.S. would mean a rapid slide toward central planning.

One stark international lesson of price controls is that they become ever more complicated and pervasive. The Canadians have resorted to increasing regulation to combat the attempts of doctors and patients to "game" the system or avoid controls. To imagine how such a system would work in the U.S. it is unnecessary to go farther than Medicare, which is very similar in design to the Canadian system, with the government setting fees and regulating hospitals and doctors. Every year the regulations grow.

Reason #6: A government-run health system inevitably would be a two-tier system based on money and political connections.

Ordinary Canadians wait patiently in line to be treated. Those with money and political clout do not. When a businessman in Toronto is told his chest pains are not serious enough to warrant immediate treatment, he takes a plane to Buffalo, New York. Trips across the border to get faster and better treatment are routine for Canadians who can afford it. Politicians also do not wait. Either they go to the U.S. or they use their connections to jump the queue. Example: When Quebec Premier Robert Bourassa was diagnosed with skin cancer in 1990, he headed straight to the National Cancer Institute, near Washington, D.C. for treatment.

It is hard to imagine a U.S. senator, or a campaign supporter of the senator, waiting for a bed in a government-run system in the U.S. A bed would be found, as well as the best doctors; others would wait. Or the senator, like others with healthy incomes, would go to wherever he could get private treatment.

HOW A CONSUMER CHOICE SYSTEM WOULD WORK

Under a consumer choice approach, there would be changes in tax law and insurance regulations to empower the consumer to exercise greater control over the health care economy. Essentially, the aim would be to introduce the same market dynamics in health care—with consumers seeking the best value for money and providers competing for the consumer dollar—that work so efficiently in the rest of the economy.

One consumer-based system has been proposed by The Heritage Foundation, and is known as the Heritage Consumer Choice Health Plan.[7] This will be the subject of Part II of this series of *Talking Points*.

Another, very similar proposal has been advanced by the Washington D.C.-based American Enterprise Institute.[8] Still another by the Dallas-based National Center for Policy Analysis.[9] And while the recently announced health reform plan of the Bush Administration is less sweeping than these proposals, it contains some key elements of the consumer choice approach.

While these models do differ significantly in detail, they tend to include similar steps. These are:

☑ **Step #1: Consumers would have the same tax breaks whatever the source of their health plan, not just for employer-based plans.**

By giving the same tax benefits to the purchase of health care insurance whether a plan is obtained by a family through an employer, a union, directly from an insurance company, or from any other source, consumers would be given the opportunity and incentive to "shop around" for the best value and not to overinsure. In addition, employees of small firms would have roughly the same choices as employees of large firms. Some proposals would set up a "health care IRA," or tax-free savings account, and a family could use this money to buy insurance or to pay for medical services.

☑ **Step #2: More assistance would go to those who need it most to obtain health care.**

Unlike today's system, in which the biggest tax breaks go to those who have the biggest incomes and the most generous company-sponsored plans, the consumer choice plans would give most help to those who need it most. This generally is accomplished by introducing a refundable tax credit in place of the

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7 See footnote 1.

8 Mark Pauly, Patricia Danzon, Paul Feldstein, and John Hoff, "A Plan for 'Responsible National Health Insurance,'" *Health Affairs*, Volume 10, No. 1, Spring 1991.

9 *An Agenda for Solving America's Health Care Crisis* (Dallas, Texas: The National Center for Policy Analysis, 1991).

current tax exclusion for company plans. Tax credits do not favor upper-income families, and with a refundable credit the family receives a check from the Treasury if its tax credit exceeds its tax liability—so families too poor to pay much tax also are helped.

☑ **Step #3: Regulations currently thwarting innovative health plans would be ended.**

State mandates on insurance companies, federal and state insurance rules, and federal anti-trust regulations all make it difficult for new types of health plans to emerge to serve the consumer. Consumer choice plans thus include provisions to reduce this red tape, to increase competition among health care providers. Some include federal preemption of state laws, others would make it easier for plans to avoid these or federal rules.

Q. What would a consumer-based system mean for American families?

A. It would mean that families could shop around for the best combination of quality and price in health insurance, just as they do with other insurance purchases, and get the same tax relief wherever they obtained a plan. That would make health insurance like life insurance or mortgage payments, in that tax relief has nothing to do with the place of work.

It would also mean, just as with other forms of insurance, that the family would not lose its coverage just because the policyholder changed jobs or suffered a spell of unemployment. Thus it would solve the main problems faced by Americans families who move or lose their jobs.

Q. Wouldn't families have to become experts in health care?

A. No more than one has to become an engineering expert to buy a car, or an architect to buy a house. In major purchases of this kind, families consult experts to help them make choices, or they choose a product from a trusted organization or seller. The same would be true in health care. Typically families would not choose to bargain with individual doctors over the cost of services, any more than they bargain with auto component manufacturers and have a car built for them. Instead they would choose a comprehensive health plan.

Further, they would normally turn to a trusted plan sponsor or an expert to help them make a decision. A typical family might choose a plan sponsored by their union, or church, or they might simply ask their family doctor or insurance broker to recommend a plan.

Q. How would consumer-based systems control costs?

A. They would do so in the same way that consumer choice achieves cost control in every other major area of the economy: consumers sensitive to price seeking the best value for money.

Q. Is there any evidence that such a plan works?

A. Yes. Large corporations with "cafeteria" plans that include a range of health care options for their employees have seen their costs rise less rapidly. Even more striking, the Federal Employee Health Benefits Program (FEHBP), which covers nearly 10 million federal workers and their families, as well as retirees, gives civil servants a wide range of plans and the financial incentive to choose the best value for money. The result: Over the last decade the rise in costs in the FEHBP has averaged about two percentage points less than in the private sector. During the last three years, the premium increases have averaged about half that of the private sector.[10]

CONCLUSION

The debate over health care is one of the most important domestic policy discussions since Congress debated the creation of the Social Security system in the 1930s. The decisions that Congress makes will involve close to one trillion dollars a year in current spending. The pocketbooks of every American will be affected, as will their health.

Reform of the health care system thus must not be the product of election-year posturing and rhetoric. It must be based instead on careful attention to the facts, and there must be reasoned discussion of the causes of today's problems and the merits of rival reform options. If Congress debates health care reform in this way, it will be possible for the U.S. to create a comprehensive health care system that becomes the envy of the world.

10 Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation *Backgrounder* No. 878, February 6, 1992.

THE INDIVIDUAL TAX CREDIT PROGRAM: ESTIMATED COST AND IMPACTS

FINAL REPORT

Prepared For:

The Heritage Foundation

Prepared By:

Lewin/ICF

January 31, 1992

OVERVIEW OF PLAN

- ALL PERSONS ARE REQUIRED TO PURCHASE INSURANCE UNLESS THEY ARE OTHERWISE COVERED UNDER MEDICARE OR MEDICAID. THE MEDICARE AND MEDICAID PROGRAMS ARE RETAINED IN THEIR CURRENT FORM.

- THE TAX EXCLUSION FOR EMPLOYER HEALTH BENEFITS IS REPLACED WITH A REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE PREMIUMS AND UNREIMBURSED MEDICAL EXPENSES.

- THE PRIVATE INSURANCE MARKET WOULD BE REFORMED TO MAKE A STANDARD BENEFITS PACKAGE AVAILABLE TO ALL.

- STATE MANDATED BENEFITS WOULD BE PREEMPTED AND RESTRICTIONS ON MANAGED CARE PLANS WOULD BE ELIMINATED.

FEDERAL RESPONSIBILITY

- EXISTING HEALTH TAX EXPENDITURES ELIMINATED ($77.4 BILLION).
  - -- Federal tax exclusion for employer sponsored health benefits: $66.6 billion
  - -- Federal tax deduction for health expenses over 7.5% of AGI: $ 2.5 billion
  - -- State tax exclusion for employer sponsored health benefits: $ 8.3 billion
- REFUNDABLE TAX CREDIT FOR PREMIUMS AND UNREIMBURSED MEDICAL EXPENSES
  - -- Applies only in months not on Medicare or Medicaid
  - -- IRS rules on countable expenses
- TAX CREDIT VERSION #1
  - -- 80 percent of premiums up to $275 per family member, plus
  - -- 18 percent of premiums over $275 per member, plus
  - -- 18 percent of unreimbursed medical expenses.
- TAX CREDIT VERSION #2

Premiums and Unreimbursed Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10%	21%
10% - 20%	45%
20% or More	65%

a Includes the health care Earned Income Tax Credit (EITC) and deductions for self employed.

FEDERAL RESPONSIBILITY (Continued)

- **TAX CREDIT VERSION #3**
  - -- 75 percent of premiums up to $275 per family member, plus 14 percent of premiums over $275 plus;

Unreimbursed Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10%	18%
10% - 20%	36%
20% or More	55%

INDIVIDUAL RESPONSIBILITY

- ALL PERSONS NOT OTHERWISE COVERED BY MEDICARE OR MEDICAID ARE REQUIRED TO PURCHASE INSURANCE.

- MINIMUM STANDARD COVERAGE REQUIRED FOR ALL AMERICANS
  - -- $1,000 deductible ($2,000 per family)
  - -- $5,000 cost-sharing maximum

BENEFIT	COINSURANCE
Inpatient Hospital Services (365-day per stay maximum)	80%
Outpatient Hospital Services	80%
Hospital Alternatives (extended or home health care)	Yes
Physician Services	75%
Prenatal/Well-Baby/Well-Child Care	75%
Diagnostic Tests	75%
Prescription Drugs (inpatient)	75%
Emergency Services	100%
Mental Health Care	Not Covered
Dental Care	Not Covered
Vision Care	Not Covered

- AVERAGE MONTHLY COST OF THE PLAN IS $69.33 PER PERSON.

- ACTUARIAL EQUIVALENT ALTERNATIVES ARE PERMITTED.

EMPLOYER RESPONSIBILITY

- **EMPLOYERS HAVE THE OPTION OF:**
  - -- Continuing to provide health benefits; or
  - -- Discontinuing the health plan

- **EMPLOYERS WHO CONTINUE TO PROVIDE BENEFITS:**
  - -- The average amount of the employer's contribution is counted as taxable income to the employee[a]
  - -- Employees may not take cash in lieu of coverage.

- **EMPLOYERS WHO DISCONTINUE COVERAGE**
  - -- Employers must maintain their current level of effort by converting benefits to income
  - -- Employers may facilitate administration by deducting premiums for workers.

- **EMPLOYERS WILL HOLD WORKERS HARMLESS FOR THE EMPLOYER SHARE OF INCREASED FICA TAX PAYMENTS DUE TO TAXATION OF BENEFITS.**

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a Separate employer contribution amounts would be used for persons with single and family coverage.

STRUCTURE OF INSURANCE MARKET

- INDIVIDUALS CHOSE AMONG CARRIERS COMPETING ON THE BASIS OF PRICE AND QUALITY.
- CURRENT MARKETING/UNDERWRITING PRACTICES MODIFIED
  - -- In first year of program uninsurable individuals are randomly assigned to carriers.
  - -- In the initial year of the program, insurers must extend coverage to all persons they now cover.
  - -- In coverting employer group coverage to individual or family coverage, premiums are permitted to vary by no more than 25 percent from average premiums within age, sex and geographic groups.
- REFORM OF RENEWAL PRACTICES
  - -- Guaranteed renewal
  - -- Renewal premium updated by carrier-wide average increase
  - -- Changes in renewal premiums due to changes in health status are prohibited.
- STATE MANDATES ARE PREEMPTED BY STANDARD BENEFIT PACKAGE.
- LAWS RESTRICTING SELECTIVE CONTRACTING AND MANAGED CARE PLANS ARE PROHIBITED.

FINANCING

- **THE FEDERAL TAX CREDIT WILL BE REVENUE NEUTRAL.**
  - -- **Tax credit financed by elimination of existing health tax expenditures**
  - -- **Tax credit levels adjusted to be revenue neutral.**

- **STATE AND LOCAL GOVERNMENTS WILL TRANSFER TO THE PUBLIC PROGRAM NET SAVINGS IN HEALTH SPENDING TO ASSIST IN FINANCING THE FEDERAL TAX CREDIT.**

KEY ASSUMPTIONS

- **EMPLOYERS WHO NOW OFFER INSURANCE**
  - -- All will discontinue coverage and convert benefits to wages
  - -- All firms that now insure will arrange for payroll deductions to reduce insurance administrative costs.
  - -- Firms with over 1,000 workers are also assumed to establish employee premium financed cafeteria plans to further reduce administrative costs.

- **WORKERS NOW COVERED BY EMPLOYER INSURANCE**
  - -- Those in poor/fair health will select plans that maintain their existing level of coverage
  - -- Those in good/excellent health will downgrade to the standard package
  - -- Health services utilization for persons who downgrade coverage will decline based upon price elasticities reported in the literature (a price elasticity of -0.2 was selected).

- **PERSONS NOW COVERED BY NON-GROUP INSURANCE**
  - -- Persons who now have coverage in excess of the minimum standard will maintain that coverage
  - -- Others will upgrade to minimum standard.

- **CURRENTLY UNINSURED PERSONS**
  - -- All will take the minimum standard package
  - -- Utilization will adjust to levels reported by insured persons with similar characteristics.

- **WE ASSUME NO CHANGE IN THE NUMBER OF PERSONS ENROLLED IN MEDICAID.**

ADMINISTRATIVE COST ASSUMPTIONS

- ADMINISTRATIVE COSTS WOULD BE THE SAME AS UNDER CURRENT POLICY FOR WORKERS IN FIRMS WHERE THE EMPLOYER ARRANGES EMPLOYEE DEDUCTIONS

- ADMINISTRATIVE COSTS FOR OTHERS PURCHASING INDIVIDUAL INSURANCE WOULD BE 21.9 PE R :ENT OF CLAIMS. THIS RETENTION RATE WAS ESTIMATED AS FOLLOWS:

ADMINISTRATIVE COSTS FOR INDIVIDUAL COVERAGE AS A PERCENTAGE OF CLAIMS

	Current Policy[a]	Assumed Level Under Tax Credit[b]
Claims Administration	9.3%	8.0%
General Administration	12.5	10.0
Interest Credit	-1.5	-1.5
Risk and Profit	8.5	2.7
Commissions	8.4	0.0
Premium Taxes	2.8	2.7
Total	40.0%	21.9%

a Hay/Huggin estimates of administrative costs for groups with 1 to 4 members under current policy.

b Hay/Huggins estimates of administrative costs for groups with 1 to 4 members under a voluntary risk pooling arrangement adjusted to assume that insurer profits as a percent of claims corre..pond to the national average observed in the current system.

SOURCE: Congressional Research Service, "Cost and Effects of Extending Health Insurance Coverage," Washington, DC, October 1988.

IMPACT ON NATIONAL HEALTH SPENDING

Table 1
CHANGE IN NATIONAL HEALTH SPENDING BY SOURCE OF PAYMENT
(In Billions)

		Change in Spending
IMPACT ON PAYORS		
Household Payments		129.9[a]
Premium Payments	88.2	
Cost-of-Pocket Spending	62.7	
Tax Credits	(84.9)	
Eliminate Tax Exclusion	63.9	
Private Employers[b]		(112.4)
Federal Government[b]		(5.1)
State Governments[c]		(23.2)
NET CHANGE IN HEALTH SPENDING		
Changed in Health Spending		(10.8)
Utilization for Newly Insured	8.9	
Utilization for Currently Insured	(21.8)	
Insurer Administrative Costs	2.1	

a The increases in household health spending will be offset by increased wages of $148.7 billion.

b Reflects elimination of employee coverage. Employer savings in health spending will be offset by increases in wages not shown here.

c Reflects elimination of employee coverage and savings to county hospitals.

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

IMPACT ON FEDERAL SPENDING

Table 2
SOURCES AND USES OF FEDERAL FUNDS UNDER THE TAX CREDIT PROGRAM IN 1991
(in billions)

SOURCES OF FUNDS		USES OF FUNDS	
Elimination of Tax Exclusion	$66.6	Tax Credits	$84.9
Federal Income Tax 39.7 OASDI Payroll Tax 21.2 HI Payroll Tax 5.7		Civil Service Plan Health Benefits (4.6) Wages 4.6 OASDI and HI Taxes 0.5	0.5
Eliminate Deduction for Health Expenditures in Excess of 7.5 Percent of AGI	2.5	Corporate Income Tax Loss[a]	2.5
Contribution from State and Local Governments	18.8		
Total Sources of Funds	$87.9	Total Uses of Funds	$87.9

a We assume that the full amount of the employer share of the increase in OASDI and HI payroll taxes is absorbed by employers as reduced profits resulting in a change in corporate income tax payments.

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

IMPACT ON STATE AND LOCAL SPENDING

Table 3
SOURCES AND USES OF STATE FUNDS UNDER THE TAX CREDIT PROGRAM IN 1991
(in billions)

CHANGES IN REVENUES			CHANGES IN EXPENDITURES	
Elimination of State Income Tax Exclusion[a]		$8.3	Public Hospitals	$(13.2)
Premium Taxes[b]		(0.1)	State and Local Worker Benefits	2.0
Current Revenues	1.6		Health Benefits	(23.8)
Revenues Under Policy	1.5		Wages	23.8
			OASDI and HI Taxes	2.0
State Corporate Income Tax Loss		(0.6)	Contribution to Federal Tax Credit	18.8
Net Change in Revenues		$7.6	Net Change in Expenditures	$ 7.6

a The increase in wages under the program will result in an increase in state income tax payments.

b Premium tax revenues decline due to the reduction in health insurance coverage under the tax credit program.

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

IMPACT ON EMPLOYER SPENDING

Table 4
CHANGE IN PRIVATE EMPLOYER HEALTH SPENDING UNDER THE TAX CREDIT PROGRAM IN 1991
(in billions)

	Change in Spending
Current Employer Expenditures for Health care[a]	$124.3
Convert Employee and Dependent Benefits to Wages[b] Benefit Payments (120.2) Wages 120.2	0.0
OASDI and HI Tax on Benefits (Employer Share)	10.9
Change in Employer Costs	10.9
Change in Corporate Taxes	(3.1)
Net Change in Employer Costs (Change in Costs Per Worker of $104.8)	$7.8

a Includes the employer share of expenditures for workers, dependents and retirees.

b Employer contributions for worker and dependent benefits are converted to wages. Retiree coverage is assumed to be retained.

c The entire amount of the increase in OASDI and HI payroll taxes is assumed to be absorbed by employers as reduced profits resulting in a change in corporate income taxes.

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

IMPACT ON HOUSEHOLD HEALTH SPENDING

Table 5
CHANGE IN HOUSEHOLD HEALTH SPENDING
(In Billions)

Health Spending		
Premium Payments		$ 88.2
Employee Contribution in Employer Plans	(45.2)	
Individual Premium Payments	133.4	
Out-of-Pocket Expenses		62.7
Tax Credit		(84.9)
Eliminate Tax Expenditures (individual share)		61.4
Federal	53.1	
State	8.3	
Eliminate Health Expense Deduction (over 7.5% AGI)		2.5
Net Change in Health Spending		129.9
WAGE EFFECT		
Increased Wages (offset to change in health spending)		(148.7)
Net Impact on Households		$(18.8)

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

Table 6
FAMILIES BY ANNUAL OUT-OF-POCKET EXPENSES AND PREMIUM PAYMENTS UNDER CURRENT LAW IN 1991[a,b]

Total Out-of-Pocket Expenses and Premiums	Families (millions)	Total Family Spending (billions)
0 - 500	4.3	$ 0.4
500 - 1,000	8.5	6.7
1,000 - 2,500	18.8	32.5
2,500 - 5,000	28.2	103.3
5,000 - 10,000	15.1	100.3
10,000 - 20,000	2.0	24.1
20,000 - 30,000	0.1	2.3
30,000+	0.1	4.0
TOTAL	77.2	$273.7

a Includes premiums and direct payments for care before tax credits.

b Includes families where the household head is under age 65.

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

DISTRIBUTIONAL IMPACT OF ALTERNATIVE TAX CREDIT FORMULAS

FEDERAL TAX CREDIT ALTERNATIVES

- TAX CREDIT VERSION #1
  - -- 80 percent of premiums up to $275 per family member, plus
  - -- 18 percent of premiums over $275 per member, plus
  - -- 18 percent of unreimbursed medical expenses.
- TAX CREDIT VERSION #2

Premiums and Unreimbursed Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10%	21%
10% - 20%	45%
20% or More	65%

Table 7
FEDERAL AND STATE TAX CREDIT AMOUNTS
UNDER ALTERNATIVE FORMULAS IN 1991
(in billions)

Federal Tax Credit Formula	TAX CREDIT AMOUNT	
	Before Budget Neutral Adjustment	After Budget Neutral Adjustment*
Version #1	$104.9	$84.9
Version #2	100.1	84.9
Version #3	$115.9	$84.9

* All analyses reflect budget neutral adjustments to the tax credit formula.

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

FEDERAL TAX CREDIT ALTERNATIVES (Continued)

- **TAX CREDIT VERSION #3**
  - -- 75 percent of premiums up to $275 per family member, plus 14 percent of premiums over $275, plus

Unreimbursed Expenses as a Percent of Gross Income	Percent Reimbursed
Below 10%	18%
10% - 20%	36%
20% or More	55%

Table 8
AVERAGE NET IMPACT OF ALTERNATIVE TAX CREDIT OPTIONS ON FAMILIES BY FAMILY INCOME 1991[a]

		FAMILY INCOME								
	All Households	Less Than $10,000	$10,000-$14,999	$15,000-$19,999	$20,000-$29,999	$30,000-$39,999	$40,000-$49,999	$50,000-$74,999	$75,000-$99,999	$100,000 or More
Household health spending under current law	$1,841	$887	$1,223	$1,428	$1,638	$1,906	$1,954	$2,295	$2,488	$3,230
CHANGES IN HEALTH SPENDING										
Change in premium payments[b]	1,214	671	930	991	1,100	1,279	1,312	1,459	1,679	1,854
Change in out-of-pocket payments for care	692	108	286	367	519	769	988	1,059	1,053	1,176
Elimination of state and federal tax expenditures[c]	745	35	154	283	500	736	875	1,330	1,507	1,492
WAGE EFFECTS										
Increased wages (counted as an offset to health spending)	(1,767)	(162)	(637)	(1,119)	(1,531)	(2,060)	(2,313)	(2,681)	(2,754)	(2,779)
TAX CREDITS (FEDERAL AND STATE)										
Version #1	(1,052)	(422)	(669)	(810)	(959)	(1,222)	(1,242)	(1,360)	(1,395)	(1,530)
Version #2	(1,052)	(734)	(871)	(978)	(1,045)	(1,258)	(1,168)	(1,141)	(1,082)	(1,170)
Version #3	(1,052)	(526)	(724)	(853)	(966)	(1,245)	(1,234)	(1,289)	(1,298)	(1,488)
CHANGE IN AFTER-TAX HEALTH SPENDING NET OF AFTER-TAX CHANGE IN INCOME										
Version #1	(168)	210	44	(288)	(371)	(498)	(378)	(193)	(20)	242
Version #2	(168)	(82)	(158)	(456)	(457)	(534)	(304)	(26)	293	574
Version #3	(168)	126	(11)	(331)	(378)	(521)	(379)	(122)	77	344

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation.
b Includes individual premium payments less employee contributions to employer plans eliminated under the tax credit proposal.
c Includes the additional taxes paid on employer benefits converted to income including, federal income taxes, the employee share of OASDI and HI payroll taxes, and state income taxes.

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

Table 9

DISTRIBUTION OF FAMILIES BY CHANGE IN HEALTH SPENDING NET OF CHANGES IN AFTER TAX INCOME UNDER THE TAX CREDIT PLAN IN 1991[a,b]

Change in Health Spending Net of Changes in Income[c]	TAX CREDIT MODEL		
	Version #1	Version #2	Version #3
Net Increase of $20 or More	42.2%	45.2%	43.4%
$1,000 or More Increase	17.3	17.7	17.7
$500 - $999 Increase	9.0	11.8	9.3
$250 - $499 Increase	9.4	8.6	10.0
$100 - $249 Increase	4.4	4.5	4.0
$20 - $ 99 Increase	2.1	2.6	2.4
No Net Change (change of less than $20)	3.9%	3.7	3.6
$20 - $ 99 Decrease	4.0	4.1	3.8
$100 - $249 Decrease	5.5	6.0	5.6
$250 - $499 Decrease	8.2	9.0	8.5
$500 - $999 Decrease	13.2	12.1	13.1
$1,000 or More Decrease	23.1	19.7	21.8
Net Decrease of $20 or More	54.0%	50.9	52.8
All Families	100.0%	100.0%	100.0%

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

b Includes only families with head under age 65.

c Includes the increase in wages under the program less the net change in household health spending including: changes in premiums and out-of-pocket spending; taxes on increased wages; and tax credits.

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

Table 10
(Tax Credit - Version #1)

DISTRIBUTION OF FAMILIES BY THE AMOUNT OF THE CHANGE IN TOTAL FAMILY HEALTH CARE EXPENSES FOR PREMIUMS AND OUT-OF-POCKET COSTS (INCLUDES ONLY FAMILIES WITH HEAD UNDER AGE 65)[a]

		PERCENT OF ALL FAMILIES BY TOTAL FAMILY INCOME										
		Increase in Family Health Costs						Reduction in Family Health Costs				
Family Income	All Families	1,000+	500-999	250-499	100-249	20-99	No Change	20-99	100-249	250-499	500-999	1,000+
<$10,000	100.0%	10.8%	13.6%	23.0%	3.1%	1.0%	18.0%	10.2%	6.2%	4.4%	4.4%	5.3%
$10k-$14,999	100.0	17.7	14.8	15.5	2.0	1.1	4.5	6.0	5.0	6.5	10.4	16.3
$15k-$19,999	100.0	15.5	7.8	10.8	3.6	2.5	3.0	3.5	5.3	10.5	17.1	20.4
$20k-$29,999	100.0	16.3	8.3	8.1	4.3	2.1	1.4	1.9	7.7	10.0	15.9	23.9
$30k-$39,999	100.0	16.1	8.4	5.8	6.2	2.3	0.7	2.4	4.7	8.0	11.8	33.5
$40k-$49,999	100.0	18.3	5.9	4.8	5.4	3.0	1.6	2.6	5.7	7.3	14.1	31.2
$50k-$59,999	100.0	20.1	6.8	4.5	4.4	2.5	1.1	2.2	4.6	10.0	16.3	27.4
$75k-$100,000	100.0	20.0	6.9	4.5	6.2	2.6	0.0	4.1	5.2	8.8	16.0	25.8
$100,000+	100.0	26.9	11.0	8.2	2.9	1.2	0.0	2.7	3.7	7.0	15.1	21.3
TOTAL	100.0	17.3	9.0	9.4	4.4	2.1	3.9	4.0	5.5	8.2	13.2	23.1

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

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

Table 11
(Tax Credit - Version #2)

DISTRIBUTION OF FAMILIES BY THE AMOUNT OF THE CHANGE IN TOTAL FAMILY HEALTH CARE EXPENSES FOR PREMIUMS AND OUT-OF-POCKET COSTS (INCLUDES ONLY FAMILIES WITH HEAD UNDER AGE 65)[a]

		PERCENT OF ALL FAMILIES BY TOTAL FAMILY INCOME										
		Increase in Family Health Costs					No Change	Reduction in Family Health Costs				
Family Income	All Families	1,000+	500-999	250-499	100-249	20-99		20-99	100-249	250-499	500-999	1,000+
<$10,000	100.0%	5.3%	13.7%	15.7%	5.7%	2.4%	15.7%	9.7%	7.3%	8.0%	8.0%	8.5%
$10k-$14,999	100.0	13.8	25.2	4.2	4.5	3.3	3.9	4.4	5.2	6.5	9.7	19.5
$15k-$19,999	100.0	13.0	12.2	8.5	3.2	2.5	2.4	4.2	5.9	12.7	13.7	21.7
$20k-$29,999	100.0	14.5	11.7	8.1	3.0	2.5	2.5	3.8	6.4	9.2	15.5	22.7
$30k-$39,999	100.0	16.8	9.7	8.2	5.1	2.4	1.5	2.1	5.5	7.7	12.9	28.2
$40k-$49,999	100.0	19.9	8.2	9.2	5.0	2.7	0.8	3.2	5.4	8.1	15.3	22.2
$50k-$59,999	100.0	23.8	10.1	6.9	5.0	1.8	1.0	2.6	5.9	12.2	10.4	20.2
$75k-$100,000	100.0	25.6	10.1	7.1	4.6	4.1	1.6	2.5	6.1	7.6	14.4	16.3
$100,000+	100.0	37.5	9.6	5.2	2.4	4.7	0.7	3.8	4.6	4.7	9.7	17.2
TOTAL	100.0	17.7	11.8	8.6	4.5	2.6	3.7	4.1	6.0	9.0	12.1	19.7

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

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

Table 12
(Tax Credit - Version #3)

DISTRIBUTION OF FAMILIES BY THE AMOUNT OF THE CHANGE IN TOTAL FAMILY HEALTH CARE EXPENSES FOR PREMIUMS AND OUT-OF-POCKET COSTS (INCLUDES ONLY FAMILIES WITH HEAD UNDER AGE 65)[a]

		PERCENT OF ALL FAMILIES BY TOTAL FAMILY INCOME										
		Increase in Family Health Costs						Reduction in Family Health Costs				
Family Income	All Families	1,000+	500-999	250-499	100-249	20-99	No Change	20-99	100-249	250-499	500-999	1,000+
<$10,000	100.0%	9.5%	12.6%	21.1%	3.9%	2.3%	16.1%	9.4%	6.2%	6.3%	6.0%	6.7%
$10k-$14,999	100.0	16.6	15.1	15.9	1.9	2.5	4.0	5.2	4.8	7.0	10.4	16.6
$15k-$19,999	100.0	15.1	8.5	11.5	3.9	2.7	2.3	3.8	5.2	10.9	16.8	19.5
$20k-$29,999	100.0	16.1	9.0	7.6	5.0	1.6	0.9	3.5	7.7	10.2	14.5	23.8
$30k-$39,999	100.0	16.6	9.5	8.3	4.0	2.1	1.2	2.5	5.2	7.9	11.2	31.6
$40k-$49,999	100.0	19.6	5.6	6.2	6.0	3.5	0.8	1.8	7.2	5.1	15.9	28.5
$50k-$59,999	100.0	21.3	7.4	6.0	3.3	3.2	1.2	2.8	4.1	10.4	16.6	23.6
$75k-$100,000	100.0	21.5	6.9	8.1	4.4	1.5	1.9	2.4	4.5	10.3	14.9	23.4
$100,000+	100.0	30.6	12.0	5.3	2.7	1.3	1.5	0.9	5.6	8.3	11.0	20.7
TOTAL	100.0	17.7	9.3	10.0	4.0	2.4	3.6	3.8	5.6	8.5	13.1	21.8

a Assumes tax credits are set at levels which result in no net change in public expenditures for health care. Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

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

Table 13

CHANGE IN AVERAGE FEDERAL TAX BENEFITS PER FAMILY BY FAMILY INCOME UNDER THE TAX CREDIT PLAN IN 1991

		NET CHANGE IN TAX BENEFITS		
	Current Tax Exclusion	Tax Credit Version #1	Tax Credit Version #2	Tax Credit Version #3
Family Income				
Less Than $10,000	$ 50	$372	$684	$476
$10,000 - $14,999	207	462	664	517
$15,000 - $19,999	366	444	612	487
$20,000 - $29,999	594	365	451	372
$30,000 - $39,999	857	365	401	388
$40,000 - $49,999	986	256	182	248
$50,000 - $74,999	1,373	(13)	(232)	(84)
$75,000 - $99,999	1,427	(32)	(345)	(129)
$100,000 or More	1,463	47	(285)	(55)
All Families[a]	$ 802	$250	$250	$250

a Includes federal income taxes and the employer and employee share of the OASDI and HI payroll taxes.
b The tax credits are structured to be budget neutral.

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

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

Thank you Mr. Chairman. Today we will discuss two very different types of health care reform proposals. First, proposals in which the federal and state governments play a key role in the provision of health care services and regulation of spending on health care. Secondly, we will discuss the Administration's reform proposal, which is a market-based approach. I look forward to hearing about this proposal in greater detail.

With respect to universal approaches, clearly, there are things we can learn from other nations. This type of program has much appeal in that it provides universal access to health care services and guarantees cost containment. The Canadian system's ability to provide access to primary and preventive care services is something we should strive toward. However, the Canadian health care system, and many of the proposals to be discussed here today rely on global budgeting as a means of cost containment. I have serious concerns about how such an approach would translate into our health care system. In February of this year, President Bush outlined a health care reform proposal. Parts of that proposal have been introduced in Congress. Yesterday, Secretary Sullivan announced the transmittal of the Health Insurance Information Reform Act of 1992 which, when fully implemented, will reduce administrative costs in our health care system and provide consumers with more information in the selection of health care providers based on quality and cost. I commend Secretary Sullivan and others in the Administration for their continued efforts in this area. I am hopeful that some of their ideas will form a basis for compromise in enactment of a health care reform bill.

I look forward to hearing the testimony of today's witnesses and hope that hearings such as this will lead us to agreement in the near future on how to address this crisis in our health care system.

PREPARED STATEMENT OF SENATOR DAN COATS

I want to thank Senator Bentsen and my colleagues on the Senate Finance Committee for providing me with an opportunity to discuss the important issue of improving tax incentives for health care reform. I also appreciate your inviting my good friend, J. Patrick Rooney, to today's hearing. The concept that I am advancing in the HealthSave proposal, is a Hoosier bred idea which Pat has been advocating across the country for some time. Pat has devoted tireless hours to widening access for the uninsured and lowering the health care costs for working men and women who presently have health insurance.

Today it is becoming strikingly clear that the delivery of health care in the United States of America needs to be reformed. The status quo is unacceptable. I am convinced the real dividing line in this debate is whether government control of health care is the answer or whether solutions are to be found in the choices of the private sector.

Today people are many times insulated from the true cost of health care and false security is provided through insurance. The Congressional Budget Office recently reported that,

> "a major reason for high and rapidly health costs is the failure of the normal discipline of the marketplace to limit the quantity of services supplied."

To resolve this problem, I offered S. 2540, with the support of Senators Cochran, Gorton, Lugar, and Smith in early April of this year. The bill is titled HealthSave and it now has seven cosponsors. HealthSave would function similar to an individual retirement account by allowing individuals to save tax free for incidental medical expenses. Health care insurance would be used for its fundamental purpose—large medical expenses. Under HealthSave, the employer would be encourged—not mandated—to purchase an umbrella policy for large medical bills to cover the costs of catastrophic events. HealthSave would then allow an employer to provide each worker an allowance for medical care—up to $3,000 which would be adjusted to inflation. With the $3,000, an employee could purchase additional coverage and have resources to cover deductibles.

Any money left unspent would belong to the employee. Unlike section 125 of the Internal Revenue Code, the employee would not be forced to use it or lose it. Instead, money not used for health care could accrue tax free in the health savings account, similar to an IRA, an be used for future medical expenses, longterm care, or retirement.

Let me put it in human terms. A woman from Indianapolis recently called a local hospital to find out the costs of mammogram. When told the costs would be $250,

she asked if the hospital ever offered specials—and was told that during mother's day week, the price dropped to $50. If HealthSave were in effect, this kind of wise medical shopping would increase—and the quality and cost savings to health care consumers would increase accordingly. HealthSave would enable this constituent to choose her own doctor, make her own health decision, and would provide financial incentives for a healthier lifestyle.

In closing, I believe we must become wiser in the way we live and the way we purchase health care. We must begin to be more honest, begin to be more realistic, and begin to have the courage to face the real causes of the health care cost dilemma. To accomplish this goal, we need to accept personal responsibility for choices that determine our health and realize that health services do not naturally ensure good health.

I understand Senator Breaux, a member of this committee, will introduce a similar proposal to HealthSave today. This proposal has my support and I hope that we can work together in a bipartisan manner to advance this concept and get it passed into law. The concept we are advocating offers a way to work through the tax code and reform flexible spending accounts by empowering individuals to save money, manage their own health care costs, and reduce their medical costs.

PREPARED STATEMENT OF SENATOR WILLIAM S. COHEN

Mr. Chairman, as the Committee knows all too well, the problems plaguing our nation's health care system have reached critical proportions, and the need for reform is not just clear, it is compelling.

Ironically, at a time when American health care expenditures are skyrocketing, more and more Americans are going without needed care. As economist Lester Thurow has observed, "health care is becoming wealth care," as costs spin out of control and out of reach for millions of Americans.

The American health care system is the best in the world, but only for those who can afford It. The very factors that make it the best—the scientific, medical and technological advances; the highly trained specialists; the up-to-the-minute facilities and equipment—make it the most expensive. And, as expenditures climb, access declines.

Unfortunately, Americans want not only cheaper care, but better care, creating a seemingly irreconcilable conflict between quality and cost. The challenge before us is to find a way to control costs in order to guarantee access without sacrificing quality.

At last count, more than 20 health care reform bills—including my own Comprehensive Health Care Act—have been introduced in the current Congress. Some proposals, like my bill, build upon our current employer-based system by offering financial incentives to broaden access to care. Others, like the "play or pay" proposal introduced by Senators Mitchell, Rockefeller and Kennedy, build upon our existing system, but mandate coverage. Still others abandon our current system entirely in favor of a government-run, taxpayer-financed system like Canada's.

To date, most of the debate has centered on how these proposals differ. However, there is much more agreement than is generally acknowledged, and I believe that there are steps that we can and should be taking now to slow the growth of health care costs and increase access to quality care for millions of Americans.

For instance, a common element of both Republican and Democratic proposals is Insurance market reform to make coverage more available, affordable and predictable, particularly for small businesses. Ironically, the very people who need care most are the ones who cannot get insurance and are therefore excluded from the system. Insurance companies must stop competing with each other about whom to exclude and start concentrating on how to make affordable policies available for all Americans.

It is estimated that as many as one-quarter of the uninsured lack coverage because they have been priced out of the market by increases in State-mandated benefit laws. Most of us agree that it is time to preempt the more than 800 specific state-mandated benefits in order to make an affordable, basic benefit package, emphasizing primary and preventive care, available to small businesses and individuals.

Most of us agree that it is time to make insurance more affordable for self-employed Individuals and their families by granting them the same tax benefits currently granted to big business.

We all agree that we could reduce administrative costs by as much as $100 billion a year by replacing the more than 1,100 insurance forms that clog the system, with a simplified, standardized electronic claims processing system.

We agree that it is time to reform a medical liability system which spends more on legal overhead than on compensating victims, and which adds an estimated $20 billion a year to our nation's health care bill.

There is also agreement that increased funding should be provided for outcomes research to establish which drugs and procedures are most effective under which circumstances to improve quality of care and eliminate the costly practice of defensive medicine.

Most of us are concerned about the proliferation of expensive medical gadgetry and high-tech machinery that has contributed to an equally dazzling explosion in health care expenditures. These services can be delivered more efficiently and cost-effectively by encouraging hospitals and other providers to share expensive medical equipment or services.

Finally, we all know that health insurance alone will not insure good health. Americans must be encouraged to engage in healthy behavior and to accept more responsibility for their physical well-being. Investments in health promotion and prevention offer returns not only in reduced health care bills, but in longer life and increased productivity. As noted author and physician Dr. Michael Crichton has observed, "the future of medicine lies not in treating illness, but in preventing it."

Mr. Chairman, these concepts, which are all in my proposal, have also been endorsed by the Administration. They are also in your proposal, they are in the Republican Task Force proposal and in the Mitchell-Rockefeller proposal.

We have passed the point of agreement and it is now time for action. These are significant reforms that will take us closer to our goal of ensuring access to affordable health care for all Americans, and they are achievable this year.

According to the ancient Chinese proverb, "A journey of a thousand miles must begin with a single step."

With perhaps less than 50 legislative days remaining, we should be focusing not on what divides us, but on what brings us together. The reform of our nation's health care system Is perhaps the most critical challenge facing our nation in this decade. The crafting of a bipartisan agreement on these issues—and perhaps others—will lay a foundation upon which we can build more comprehensive reform in the future.

Mr. Chairman, again, thank you for the opportunity to testify.

PREPARED STATEMENT OF WILLIAM S. CUSTER

I am pleased to appear before you today to discuss employment-based health care reform proposals. My name is Bill Custer. I am the Director of Research at the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisanl public policy research organization based in Washington, DC. EBRI has long been committed to the accurate analysis of public policy employee benefit issues. Through our research, we strive to contribute to the formulation of effective and responsible health, welfare, and retirement polities. In keeping with EBRI's mission of providing objective and impartial analysis, our work does not contain recommendations.

INTRODUCTION

Presently, 64 percent of Americans under age 65 receive health insurance through an employer- or union-sponsored plan (Employee Benefit Research Institute, 1992). For most of the 138.7 million nonelderly Americans with employment-based coverage, the level of benefits offered, the range of choices in providers, treatments, and sites of care are superior to any publicly provided benefits presently offered in the United States. An EBRI/Gallup survey conducted in December 1991 found that 73 percent of Americans with health benefits rated their health benefits as excellent or good.

The employer share of national health expenditures has remained virtually constant since 1980, but national expenditures for health have grown faster than income. As a result, health benefits as a percentage of compensation (averaged over all workers whether they receive health benefits or not) have grown from 4.4 percent in 1980 to 6.3 percent in 1990 (Bureau of Economic Analysis, 1992) (table 1). An A. Foster Higgins survey conducted in 1991 found that among employers who offered health benefits, the average health plan cost was 10.9 percent of payroll.[1] Spending on employer-sponsored health plans has tripled in the last decade. In

[1] This survey is of predominantly medium- and large-sized employers.

1980, spending on employer health care benefits totaled $64.8 billion. By 1990, those expenditures had almost tripled, reaching $186.2 billion (Levit, 1991).

Table 1.—TOTAL EMPLOYER OUTLAYS FOR GROUP HEALTH INSURANCE AND MEDICARE HOSPITAL INSURANCE, AND EMPLOYER HEALTH SPENDING AS A PERCENTAGE OF TOTAL COMPENSATION, 1960–1990

Year	Employer spending of private health insurance (billions of dollars)	Employer spending on Medicare hospital insurance (billions of dollars)	Health care as a percentage of total compensation
1960	$3.4	$0.0	1.1%
1965	5.9	0.0	1.5
1970	12.1	2.3	2.3
1975	25.5	5.6	3.3
1980	61.0	11.6	4.4
1981	71.7	15.9	4.8
1982	82.6	16.8	5.2
1983	91.5	18.7	5.4
1984	100.3	20.6	5.4
1985	107.4	22.7	5.5
1986	113.7	26.1	5.5
1987	122.9	27.7	5.6
1988	138.7	29.6	5.8
1989	157.7	31.8	6.1
1990	174.2	33.6	6.3

Source: U.S. Department of Commerce, Bureau of Economic Analysis, ***Survey of Current Business, January 1992*** (Washington, DC: U.S. Government Printing Office, 1992); ***The National Income and Product Accounts of the United States, 1929–82*** (Washington, DC: U.S. Government Printing Office, 1986); and ***The National Income and Products Accounts of the United States, Statistical Supplement 1959–1988,*** vol. 2 (Washington, DC: U.S. Government Printing Office, 1992).

Health insurance costs in the private sector are not currently distributed equally among all payers. The cost of employer-sponsored health insurance depends on the characteristics of the employer's work force, risk factors attributed to the industry, and the employer's market power in the local health care services market. There are significant differences in health care costs across regions, industries, and between large and small employers.

Ultimately the costs of employment-based health insurance are borne by employees in the form of lower wages and salaries, lower levels of other benefits, and fewer jobs; by consumers in the form of higher prices for goods and services; and by taxpayers. The distribution of these costs depends on the relative market power of the employer in their input and output markets and their relative market power in the health care services market.

These considerations have led many to argue that tying the financing of health care to the labor market results in an inequitable distribution of both benefits and costs. The number of nonelderly Americans without health insurance has increased to 35.7 million. Individuals without health insurance are predominantly nonworker, self-employed, workers in small establishments, or persons in families headed by a member of one of these groups (table 2). These individuals face the highest costs of obtaining health insurance coverage, especially when those costs are calculated as a percentage of family income.

Table 2.—NONELDERLY POPULATION WITH SELECTED SOURCES OF HEALTH INSURANCE, BY INDUSTRY AND SIZE OF FAMILY HEAD'S EMPLOYER, 1990

Work status and firm size of family head	Total	Total private	Employer provided			Other private	Total public	Medicaid	No health insurance coverage
			Total	Direct	Indirect				
	[In millions]								
Total	215.9	158.3	138.7	70.3	68.4	19.7	29.2	21.6	35.7
Family Head Works	192.9	151.6	134.6	67.5	67.1	17.1	17.0	11.4	30.5
Under 25	49.7	31.8	22.5	11.0	11.4	9.3	5.3	3.8	14.0
25–99	25.2	18.5	16.8	8.4	8.3	1.8	2.5	1.9	5.0
100 or more	118.0	101.3	95.3	48.0	47.3	6.1	9.3	5.6	11.6
Family Head Does not Work	23.0	6.7	4.1	2.8	1.3	2.6	12.2	10.2	5.2

Table 2.—NONELDERLY POPULATION WITH SELECTED SOURCES OF HEALTH INSURANCE, BY INDUSTRY AND SIZE OF FAMILY HEAD'S EMPLOYER, 1990—Continued

Work status and firm size of family head	Total	Total private	Employer provided			Other private	Total public	Medicaid	No health insurance coverage
			Total	Direct	Indirect				
Self-Employed	17.6	12.7	7.7	3.4	4.3	5.0	1.2	0.7	4.1
Under 25	16.2	11.5	6.6	3.0	3.7	4.8	1.2	0.7	4.0
25–99	1.0	0.9	0.7	0.3	0.4	0.1	0.0	0.0	0.1
100 or more	0.4	0.4	0.3	0.1	0.2	0.1	0.0	0.0	0.0
Wage and Salary Workers	175.4	138.9	126.8	64.1	62.8	12.1	15.8	10.6	26.5
Under 25	33.5	20.3	15.8	8.1	7.8	4.5	4.1	3.2	10.0
25–99	24.3	17.7	16.0	8.1	7.9	1.7	2.4	1.9	4.9
100 or more	117.6	100.9	95.0	47.9	47.1	6.0	9.3	5.6	11.6
[Percentage within industry and firm size categories]									
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Family Head Works	89.3	95.8	97.0	96.1	98.1	86.8	58.2	52.8	85.4
Under 25	23.0	20.1	16.2	15.7	16.7	47.1	18.0	17.8	39.1
25–99	11.7	11.7	12.1	12.0	12.2	9.1	8.4	8.9	13.9
100 or more	54.6	64.0	68.7	68.3	69.1	30.9	31.8	25.8	32.5
Family Head Does not Work	10.6	4.2	3.0	3.9	2.0	13.0	41.8	47.5	14.5
Self-Employed	8.1	8.0	5.6	4.9	6.3	25.5	4.2	3.2	11.5
Under 25	7.5	7.3	4.8	4.2	5.4	24.6	4.0	3.1	11.1
25–99	0.4	0.5	0.5	0.5	0.6	0.8	0.1	0.1	0.2
100 or more	0.2	0.2	0.2	0.2	0.3	0.3	0.0	0.0	0.1
Wage and Salary Workers	81.2	87.7	91.5	91.2	91.8	61.5	54.0	49.3	74.0
Under 25	15.5	12.8	11.4	11.5	11.4	22.6	14.0	14.7	27.9
25–99	11.2	11.2	11.6	11.6	11.6	8.5	8.3	8.8	13.7
100 or more	54.4	63.8	68.5	68.1	68.9	30.5	31.7	25.8	32.4

Source: Employee Benefit Research Institute tabulations of the March 1991 Current Population Survey

Note: Details may not add to totals because individuals may receive coverage from more than one source.

S. 2114 and S. 1227, as well as other proposals, incorporate two general approaches for expanding employment-based health insurance to those groups not presently covered. One is to lower the costs faced by these groups in an effort to encourage them to purchase health benefits. The other is to require that they purchase health insurance from either public or private plans. Both of these approaches redistribute the costs and the benefits of health care services.

SMALL GROUP INSURANCE MARKET REFORM

Small groups often face higher costs per participant because of their higher per capita administrative costs and insurance companies' limited ability to pool risks. By removing barriers that prevent insurers from pooling small groups, employment-based coverage may expand to include many of the employed uninsured in small firms and their dependents (who constitute 39 percent of the nonelderly uninsured).

Many proposals, including S. 1227, would impose community rating with limited adjustment allowed for age and sex differences. Some analysts argue that mandating community rating or eliminating demographic adjustments would raise rates for many groups and create adverse selection.

Adverse selection occurs when individuals with greater health risks are disproportionately enrolled in a particular plan. Community rating limits insurers' ability to charge different premiums to groups on the basis of risk because the premium charged under a community rating scheme would limit the risk factors used to determine the premium. As a result, premiums for groups that represent good health risks would rise with the implementation of community rating, while premiums for groups representing bad risks would fall. Some of the good risks would choose not to purchase health insurance as a result of the premium increase, while more of the bad risks would purchase health insurance. The result would be an increase in the pool's average risk, increasing premiums and potentially creating a vicious circle that would end with an unsustainable health insurance market. The likelihood of this scenario actually occurring depends on the sensitivity of the demand for health

insurance to changes in premiums among good and bad risks as well as on the ability of individuals to determine their own risk status.

S. 1227 mandates that all Americans receive coverage through either a public or a private plan. In this case, community rating would increase the costs of insurance for the good risk groups, providing them with a greater financial incentive to choose to enroll in the public plan. Conversely, poor risks would see their premiums decrease, making it more likely they retain private benefits than under experience rating. The net impact of these incentives will depend on several factors including the payroll tax rate, the local community rates, and the perceived quality of the public plans.

Another mechanism for preventing adverse selection is to reinsure the poor risk by direct subsidization through a state risk pool. A number of proposals include measures that would encourage the creation of either public or private reinsurance pools to reduce the effects of adverse selection. These pools would allow individual insurance plans to cap the costs of the poorer risks, permitting them to offer lower premiums than would otherwise be possible.

The development of reinsurance markets, or state risk pools to subsidize the insurance costs for poor risks may alleviate some concerns about restrictions on premiums. However, public and private reinsurance schemes distribute the cost burden differently. If a private reinsurance market develops, the costs of providing expanded access to poorer risks will be borne by the purchasers of insurance. The premium paid by individuals and employers for health coverage will include the premium paid by insurers for the reinsurance of poorer risks. On the other hand, the burden of the costs of a public risk pool will depend on the financing mechanism for that pool. Most state risk pools are now financed by state insurance premium taxes.

Researchers evaluating the Robert Wood Johnson Foundation (RWJF) projects for the medically uninsured found that small employers' primary reason for not offering health insurance was the high cost of coverage—85 percent of employers not offering insurance cited high premiums as an important reason (McLaughlin, 1991). Although the RWJF demonstration projects did not reform local small group insurance markets the way that current national proposals would, their goals are similar: to stabilize the cost of insurance to small businesses and distribute these costs more equitably. Previously uninsured small employers began to offer insurance to their employees during the enrollment phase of the demonstration projects. However, only 17 percent of employers who previously did not offer insurance enrolled even in the most successful RWJF project targeted at small employers (McLaughlin, 1991). If the experience of these projects is representative of national experience, small group insurance market reform by itself may result in a minority of small employers choosing to purchase health insurance.

EMPLOYER MANDATES

Requiring all employers to provide health benefits to workers and their dependents would decrease the number of uninsured from 36 million to 10 million (table 3). Because many of the uninsured work for small firms, exempting employers with fewer than 25 employees would only reduce the number of uninsured to about 25 million. This analysis assumes that there are no changes in employment as a result of a mandate, even though health benefits represent a significant component of total compensation (10.9 percent of payroll among employers who offer health benefits) (A. Foster Kiggins & Co., 1992). Clearly, if a mandate were implemented without a transition period,, so that other elements of total compensation (such as wages) could not adjust, the cost of labor would increase substantially, possibly causing some loss of jobs.

Table 3.—COVERAGE EFFECTS OF AN ILLUSTRATIVE EMPLOYER MANDATE, 1990

[Millions]

	Present system	Number covered under	
		Small exempt mandate[1]	Universal mandate[2]
Total	248.9	248.9	248.9
Private			
Direct employer	71.2	86.6	117.7
Indirect employer	68.7	75.3	71.4
Other private	19.5	13.9	5.4

Table 3.—COVERAGE EFFECTS OF AN ILLUSTRATIVE EMPLOYER MANDATE, 1990—Continued

[Millions]

	Present system	Number covered under	
		Small exempt mandate[1]	Universal mandate[2]
Public			
Medicare	31.4	30.6	29.2
Medicaid	17.2	15.5	13.3
CHAMPUS[3]	4.8	1.8	1.0
Uninsured	36.0	24.6	10.3

[1] The mandate requires all employers with 25 or more employees to provide health insurance to employees working 25 or more hours per week.
[2] The mandate requires all employers to provide health insurance to employees working more than 19 hours per week.
[3] Civilian Health and Medical Program of the Uniformed Services.

Source: Employee Benefit Research Institute simulation using March 1991 Current Population Survey.

EBRI simulated changes in employment that would occur as a result of mandating that all employers offer health benefits (wages and other elements of total compensation were held constant). The sensitivity of employer demand for workers to changes in the price of labor is crucial in this simulation. The EBRI analysis used a range of estimates of this sensitivity based on economic literature (Hamermesh, 1986). It should be noted that other values supported by the economic literature could be cited that would increase or decrease the estimated employment effects by large amounts. The other crucial assumption used in this simulation was the costs of the mandated health benefits. Without specifying the actual component services that would be covered, separate EBRI simulations were conducted using different estimates of the average annual cost of health benefits per individual employee—$970, $1,450, and $2,430. The cost of each additional dependent was assumed to be 60 percent of the individual cost. Again, these estimates assume that wages and other benefits do not change as health benefits are added. Clearly, if wages adjust, fewer individuals would become unemployed as a result of a mandate.

EBRI's simulations estimated that between 200,000 and 1.2 million workers could become unemployed as a direct result of a mandate that employers provide health benefits to their employees. The higher estimates were the result of higher average costs of the mandated health plan and greater price sensitivity of the demand for labor.

EBRI analysis also found that the cost of an employer mandate would be borne primarily by small employers and their employees. EBRI estimated that an illustrative employer mandate would increase spending by employers on employer-sponsored health benefits by $33 billion to $86 billion. The wide range between the estimates is related to assumptions about health plan costs. If employers with fewer than 25 employees were exempt from the mandate, spending would increase by $12 billion to $33 billion. Costs for employer-sponsored health benefits would also be redistributed. Workers who had previously been covered under another employer's plan would now be covered directly under their own employer's plan. For example, under a mandate with an average health plan cost of $1,450 per individual employee and no employer size exemptions, about $20 billion in costs would be redistributed from one employer to another. About 45 percent of these transferred costs ($9 billion) would be redistributed to small employers. If small employers were exempt from the mandate, the total costs redistributed among all employers would be only about $5 billion.

The question of whether uninsured workers and their families would be better off if health insurance were extended to them under an mandate centers on the issue of whether they are uninsured by choice. Do workers select jobs that do not offer health benefits in order to receive higher levels of cash compensation or other benefits? If employees are choosing a total compensation package that does not include health benefits, any measure that forces them to accept a package with health benefits will make them worse off.

However, society may benefit by forcing individuals to purchase health insurance. Individuals who choose not to purchase health benefits are gambling that they will not need health care services. They may make that bet knowing that care will be available to them in the case of a catastrophic event. Thus, society may bear at least a part of the risk that the individual chose not to insure against.

An employer mandate is essentially a payroll tax, although the burden of that tax is not distributed equally across all employees, employers, or consumers. Some of

the costs of mandated health benefits would be passed on to employees in the form of lower wages, lower levels of other noncash benefits, or unemployment. Low-income workers would have less opportunity to trade wages for health benefits and would be more likely to experience the effects of an employer mandate in the form of unemployment. Some of the costs might be passed on to consumers in the form of higher prices. The remainder of the costs of a mandate would be borne by the investors and owners of the firms subject to the mandate. The distribution of this burden would vary by industry, region, firm size, and ownership type.

PLAY-OR-PAY EMPLOYER MANDATES

Play-or-pay proposals limit the costs that employers would face under an employer mandate by allowing employers to pay a payroll tax rather than provide health benefits. The revenue generated by the payroll tax would be used to at least partially fund a comprehensive public program.

Estimates of chases in health insurance coverage and costs of such a plan vary substantially, depending on the behavioral assumptions chosen. Simulations of these proposals must determine which employers will continue (or begin) to provide health insurance and which will instead pay the public plan to cover its employees. A recent study by the Urban Institute assumed that employers would base their choice of whether or not to participate in the plan on cost alone (Zedlewski, 1992). If their average per capita premium would be lower under the pay option, employers would enroll their workers in the public plan. The study analyzed both a 7 percent and a 9 percent payroll lax. It found that under the 9 percent tax scenario nearly 40 percent of nonelderly Americans would be enrolled in the public plan, and under the 7 percent scenario 52 percent would be enrolled in the public plan.

EBRI simulation of a play-or-pay mandate also made the assumption that employers whose actual or prospective health benefit costs were greater than the payroll tax would choose to enroll employees in the public plan rather than provide health benefits directly. Again, three different estimates of the average annual cost of health benefits per individual employee were used in the simulation—$970, $1,450, and $2,430. The cost of each additional dependent was assumed to be 60 percent of the individual cost. This simulation produced estimates which found that between 33 percent and 51 percent of all Americans would be enrolled in the new public plan if the payroll tax were set at 9 percent. The percentage of nonelderly enrolled in the public plan would range between 24 percent and 45 percent. The percentage of the previously uninsured who would gain coverage through an employment-based plan ranges from 43 percent to 78 percent. Of the new enrollees in the public plan, between 10 million and 45 million would have previously received benefits through an employer-sponsored health plan. The relative size of the public plan has important implications for the distribution of the costs of play-or-pay proposals.

Assuming that all employers whose health care costs were greater than 9 percent of payroll dropped their health benefits and paid the payroll tax (assuming a play-or play mandate with an average cost of $1,450 per employee), such a proposal could increase overall employer spending by approximately $45 billion. Employers with fewer than 25 employees would face increased costs of $18 billion.

If wages and other components of total compensation could not adjust, some unemployment would result. EBRI analysis estimated that between 131,100 and 965,000 jobs could be lost under a play-or-pay proposal with a 9 percent payroll tax. Again, as under an employer mandate, these estimates assume no transition period nor any adjustment in other components of total compensation. In practice, the impact on employment is likely to be lower than these estimates indicate,

The proportion of employers that would actually drop their health benefits if a play-or-pay proposal were enacted depends on number of factors. If the public plan were considered inferior to private plans, employers might continue to offer private health benefits in order to gain a competitive advantage in the labor market. An employer's willingness to continue health benefits may depend on the characteristics of its local health care market. Employers that lack confidence in their ability to manage their health care costs may be more likely to drop health benefits. Conversely, if the public plan attracted a large proportion of poor health risks, the cost of private insurance may fall, prompting many employers to continue to offer health benefits. The characteristics of the public plan are, therefore, the most important determinant of the willingness of employers to drop their health benefits.

S. 1227 requires that the new public program offer the same benefits as mandated of private plans. Providers would be reimbursed at levels at least equivalent to Medicare reimbursement rules. Although states would receive a federal matching grant, they would administer the program and eventually assume an increased funding role. Given the state and federal budget constraints it seems unlikely that real pro-

vider income from AmeriCare would match that available from some private plans. The public plan's ability to set fees and monitor utilization and the pressures of politically determined budgets would likely decrease most providers' income. The reduced number of private plans, coupled with employers' willingness to drop health benefits as costs increase, would limit cost-shifting to the private sector.

These factors coupled with employers desire to offer benefits that attract and retain a skilled workforce, may mean that many employers would continue to offer health benefits even if the costs of such benefits as a percentage of payroll exceeded the payroll tax. This would especially be hue if the perceived quality of care in the public plan was inferior to the quality of care received by privately insured patients.

Conversely, limits on provider revenues may reduce the number of providers, their ability to invest in technological innovation, and their ability to finance health care services research. It is unclear how this would affect the quality of care in the short run. Many argue that the United States has overinvested in health care technology and overtrained physicians. A reduction in expenditures for these purposes may free resources needed to finance care for those who have faced access barriers in the past. However, in the long-run there may be less innovation in health care and fewer of the best and the brightest entering the medical profession.

The absence of national health care reform does not imply a static health care delivery system. Public and private purchasers are independently developing and implementing cost management strategies that could potentially have profound effects con the cost, access, and quality of health care services. Changes in the way that Medicare reimburses physicians, which began to be implemented in 1992, may alter the willingness of physicians of different specialties to accept Medicare patients and thus alter the type of treatment available. Both public and private payers are refining and implementing utilization management procedures that may alter incentives to providers and consumers. Private payers are beginning to selectively contract with providers in the hope of encouraging cost-effective practice styles. While these changes have the potential to reduce the rate of health care cost inflation, they may also segment the market, further differentiating the care received by those with private health insurance, beneficiaries of public programs, and the uninsured.

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RESPONSES OF DR. CUSTER TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question. In your testimony you state that EBRI's simulations estimate a job loss of between 200,000 and 1.2 million workers as a direct result of a mandate that employers provide health benefits to their employees.

(1) First, is this simulation based on an employer mandate, as in Hawaii or as a play or pay model as in S. 1227?

(2) Second, are you familiar with the testimony presented by both Daren Davis and Prof. Ken Thorpe which cite estimates of job losses at about 50,000? These estimates use information from experience with minimum wage data. Have you taken such information into account? How do you explain the discrepancy between your estimates and those of Karen Davis and Ken Thorpe?

Answer. As you are well aware, there are a considerable number of claims and counter-claims have been made about the impact of the various health care proposals. Reputable researchers have made widely different estimates on the effects of the various reforms. These differences reflect in part the vagueness of the proposals, but also the assumptions and methodologies used to estimate their impacts.

As a non-partisan, non-profit research institute EBRI's role in the health care debate is to provide objective information on the trade-offs inherent in all the health care reform proposals. To that end we developed our own micro-simulation model to: understand how researchers arrive at widely different estimates, examine the sensitivity of those estimates to different assumptions, and understand the weaknesses in the methodologies employed.

One of the important issues of a policy in which all employers are required to provide health insurance to their employees is who bears the costs of that insurance. Policy analysts have universally concluded that the costs of that coverage are borne by employees in the aggregate. Yet analysts have developed estimates of the employment effects of an employer mandate that range 50,000 job losses to losses of over a 1 million.

EBRI simulated the effect on employment of both an illustrative employer mandate assuming that all employers would be required to offer health benefits to all employees who worked more than 19 hours a week and a play-or-pay model similar to that contained in S. 1227. There are three critical assumptions that all analysts have to make to estimate the impact of employment of a mandate: (1) how do wages and other benefits adjust when health insurance is required to be an element in total compensation; (2) how sensitive to changes in the costs of labor is employer demand for workers; and (3) how much would a mandated health plan cost. **EBRI assumed that wages and other benefits did not adjust in estimating the number of individuals who would lose their jobs as a consequence of & mandate that employers provide health benefits to their employees.** The EBRI analysis used a range of estimates of the sensitivity to changes in the costs of labor of employer demand for workers based on economic literature. Without specifying the actual component services that would be covered, separate EBRI simulations were conducted using different estimates of the average annual cost of health benefits per individual employee: $970, $1,450, and $2,430. The cost of each additional dependent was assumed to be 60 percent of the individual cost.

The range in the estimates of the number of people who would lose their jobs as a result of mandates comes from the various combinations of benefit costs and sensitivity in the demand for labor to changes in costs. The estimate of 1.2 million for example can only be reached by assuming that employers are very sensitive to costs of labor and the health benefit package is very expensive. As is apparent the estimates of job loss (and of the total costs of the policy) are extremely sensitive to the assumptions used in the simulation.

We also simulated the effects of a play-or-pay model similar to that contained in S. 1227. Using the same range of assumptions as described above, EBRI analysis estimated that between 131,100 and 965,000 jobs could be lost under a play-or-pay proposal if other labor costs did not adjust.

The analysis performed by Drs. Davis and Thorpe assumes that wages and other labor costs adjust downward to completely account for the increased costs resulting from a mandate that employers provide health insurance to their employees. As a result the employer's cost of hiring a worker does not change, and the only effect

on employment is for those workers whose wages can not adjust downward because of the minimum wage law.

Which assumption is the proper one to use depends upon the time horizon of the policy analysis. In the long run the assumption used by Dr. Davis and Dr. Thorpe maybe more accurate. In the shorter run, however, wages and other benefit costs will not have time to adjust and there will be employment effects for workers above the minimum wage. These employment effects are likely to vary by geographic region, occupation, industry, and size of employer. The effects on employment can be mitigated by announcing the policy well before implementing an employer mandate, and by transitioning small employers into the mandate at a slower rate than large employers.

The ultimate aim of these simulations was to understand who will bear the costs of expanding health insurance coverage through mandating that employers provide it to their employees. Regardless of what assumptions are used it is clear the recipient of that coverage will inevitably bear the costs of that coverage, either through loss of job or lower wages and other benefits. Arguments have been advanced on both sides of the issue of whether this is a fair, equitable, or efficient result.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

[June 8, 1992]

I appreciate this opportunity to thank the chairman for calling this series of hearings on national health-care reform and for his leadership in assembling expert witnesses to address the pluses and minuses of the proposals now before the Congress.

I also wish to put on my record my grave concerns with the proposed "play or pay" systems of financing and delivering health care. I see four major problems.

First, employer mandates just won't work. When every business must either provide insurance coverage itself or pay a specific percentage of its payroll, every business will do its own calculation of which method will be more profitable. Companies with low-cost coverage will play while companies with high-cost coverage will pay.

The government fund will get all the high-cost risks and its costs will skyrocket. That in turn will require either a higher payroll tax or greater subsidies from general revenues. If the payroll tax increases, more firms will be forced out of business by increased payroll costs that will be, after all, neither related to profitability nor negotiated with employees. Then their employees will be unemployed and uninsured.

If the payroll tax isn't increased, more and more firms will choose to pay rather than play. We'll end up doing indirectly what the bill's proponents say we wouldn't do directly: go to a single-payer system. Worse, that one-mayor system would be funded by businesses without regard to their ability to pay.

Second, we must remember that our root problem is containing the growth in health-care costs. We wouldn't have an access problem if we didn't have a cost problem. The only workable way to control the cost of our system is to change the practice of medicine, to make sure the people making the spending decisions have the incentives to get maximum health from every dollar. What won't work is controls on fees.

Our experience with fee-for-service reimbursement in Medicare and Medicaid should be a strong reminder that controlling fees is not the same as controlling costs. You also have to constrain the utilization of health care—and do it in a way that makes maximum improvement to people's health and allows continued innovation in health-care delivery.

Third, how are we going to pay for these plans? There may be administrative savings—but play-or-pay is a complicated system and I'm not all confident that administrative savings will be substantial. Even then, will these savings persist? After all, the Canadian system spends less on administration than we do, but that system hasn't been any more effective in constraining the growth in health spending.

Fourth, these packages do not have bipartisan support. I don't see consensus in the House or Senate around any of the several approaches to reform. It sometimes seems that everyone's first choice is their own plan, and their second choice is to do nothing.

Mr. Chairman, I do see bipartisan support, and support in both houses, for S. 1872, the Bentsen-Durenberger proposal to reform the small-group insurance market. I believe that bill would increase access to the system at minimal cost to the taxpayer. It is not the entire solution to the grave problems facing our health-care system, but it is an excellent step in the right direction. I'm sure you are with me in my desire to see S. 1872 become law soon.

Thank you.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

[June 17, 1992]

Good morning, Mr. Chairman, and good morning, everyone.

Our topic this morning is comprehensive health care reform, and the presence this morning of three Senators and Dr. Sullivan as witnesses demonstrates just how important this topic is.

I know there's a lot of reform proposals in the Congress, and sometimes I'm as frustrated as anyone else that there's not more consensus on the direction the country should go in. Yet all the discussion and all the proposals are encouraging signs. They signal that a lot of talented people in the Congress and the Administration and the health-care sector are grappling with very difficult issues and trying to arrive at a solution.

I commend the Administration and my colleagues Senators Kassebaum, Kerrey, Wellstone and Daschle for their initiative in bringing forth comprehensive reform proposals. I do have some questions and concerns about the various plans, especially the single-payer plans, but it's a public service for you to have worked on these proposals and to bring them forward.

When I look at single-payer plans, I can see why people are drawn to their simplicity and to the universal coverage. Many people refer to Canada, and I think it's probably true, as Owe Reinhardt commented, that the Canadian system works better for Canadians than the our system does for us.

Yet we're not Canada, of course, and we should learn from the problems they have had as well as from their successes.

Let me describe three particular areas of concern that I have with single-payer systems, and I will be very interested in any guidance that our witnesses can give the committee on these points.

First is the nature of cost containment. The plans proposed by Senators Wellstone, Daschle and Kerrey all rely to varying degrees on a "national health budget," with physicians and other providers paid on a fee-for-service basis and hospitals and other institutions paid on some kind of a fixed budget.

Those reimbursement methods are very similar to the way providers are paid in Canada, and for that matter the reliance on fee for service is just like Part B of Medicare. The problem is that Canada and Medicare Part B have failed to contain spending.

Between 1980 and 1990, inflation-adjusted cost per person rose just as fast in Canada as in the U.S.—a 52 percent increase in Canada and a 53 percent increase here. And under our Medicare program, payments to physicians rose by 155 percent—155 percent!—between 1980 and 1991, even after taking inflation into account.

The point is that cost-containment efforts that rely on fee schedules are doomed to fail.

This is made even more crucial by HCFA's projection that the number of practicing physicians will increase 20 percent between 1990 and 2000. In any other market except health, that kind of supply increase would mean lower incomes for physicians. But with fee-for-service reimbursement, the government sets the fee but the physicians set the number of services. Price control is not cost control.

The best way to control costs—and it's not something I hear about very often—is to improve the productivity of the health care system. I'm talking about changing the practice of medicine so we get more health from our health-care dollar.

This productivity improvement cannot be legislated and it cannot be ordered up by Washington officials setting some kind of a national health budget. The best we can do is to set the right incentives for the people who make the clinical decisions on a case-by-case basis. We can make the real improvements when the individual caregivers balance health benefits and resource costs in asking questions such as:

—Should this patient undergo heart surgery or will changes in diet and lifestyle do more for his health?
—Should this patient be on expensive intravenous antibiotics or inexpensive oral antibiotics?
—Will this follow-up visit do the patient any good?
—Should this person be in a hospital, a nursing home or a home-care program?

Capitation funding is often held up as one way to get the incentives right, and I'm disappointed that the single-payer plans I've seen include managed care as an afterthought, if anything.

My second area of concern about these plans—and it's also related to fee-for-service funding—is how we encourage innovation. I'm thinking about both clinical innovation—developing new treatments for patients—and innovation in delivering

health care, where the U.S. has been a world leader in managed care, new roles for health professionals and much more.

When I think of government setting national budgets and particular fees for particular services and budgets for individual institutions, I see stifling rigidity. Government can do many things, but I don't think of government as a center of innovative thinking and risk-taking.

I think risk-taking will flourish much more readily in a less centralized system. It gets back to our challenge of putting together the right balance of private enterprise and social goals.

My third area of concern is about implementation. We're talking about reorganizing $800 billion worth of economic activity, or 12 percent of the GNP of the world's largest economy. To try to change that overnight is to roll the dice with the U.S. economy.

Canada's system was put in place province by province over 23 years, starting with universal hospital insurance in Saskatchewan in 1948. Yet Senator Wellstone's proposal would create a system that would cover much more than the Canadian system—and it would create it on January 1, 1995.

We need to reform the health-care system, but we need to do it carefully. There's too much at stake to jump over the cliff and hope everything works out. Reform could be done in stages, or it could be done on a state-by-state basis.

I'd like to end my remarks by thanking the witnesses again for their contribution to the debate and by asking that they take into account the three issues I've mentioned—how to really achieve cost control, how to encourage innovation and how to implement reform.

Thank you.

PREPARED STATEMENT OF JUDITH FEDER

Mr. Chairman, members of the Committee, am pleased to be here this morning to comment on tax-incentive based approaches to health care reform. My comments will reflect my twenty years of experience in health financing research, my primary responsibility as Co-Director of the Center for Health Policy Studies at the Georgetown University School of Medicine, as well as analyses conducted under my direction as staff director of the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission).

In my view, the effectiveness of any reform proposal, whether tax-incentive based or otherwise, rests on its capacity to achieve two fundamental goals: health care coverage for all Americans and containment of health care costs. These objectives, on which most analysts agree, are critical not only on moral grounds—to ensure universal access to adequate health care. They are also essential to achieve equitable and stable health financing that neither shifts costs from one purchaser to another nor absorbs an ever-growing share of the nation's resources.

Despite their capacity to enhance access to health insurance for some Americans who now lack it, tax-incentive proposals fail to achieve these goals. Proposals designed to fill gaps in our insurance "system" leave insurance too expensive for significant numbers of the currently uninsured, do little or nothing to secure adequate coverage for the currently insured, and provide even cost-conscious purchasers insufficient support to control their health care costs. Experience tells us that, even with incentives and reforms, reliance on the marketplace alone can neither guarantee coverage nor contain health care costs.

The following raises some general questions about tax-incentive based approaches, then focuses on the potential and limitations of the specific set of initiatives the Administration has proposed.

GENERAL QUESTIONS

Although tax-incentive based proposals vary in specifics, they tend to share the following limitations:

- **Limited Coverage.** Tax credits to promote health insurance coverage among the uninsured can enhance coverage for some Americans who now lack protection. However, as contemplated in most bills, tax credits cannot guarantee the affordability of insurance. Evidence indicates that even substantial tax credits for small employers, along with reforms, will be insufficient to guarantee the availability of employer-based coverage. Without employer contributions to premiums, fixed-dollar credits that vary with income will leave the cost of insurance a "catastrophic" expense beyond the means of many moderate income families.

- **Potential Shift from Private to Public Financing.** Rather than targeting limited public resources to the population in greatest need, tax credit proposals have the potential both to undermine the provision of employer-based insurance and to substitute public for private financing for health insurance premiums. More than 25 million Americans with incomes below 200 percent of the poverty line now have health insurance from their employers. Not only would tax credits benefit those who already have insurance; the availability of tax credits could also lead employers of low wage workers to discontinue coverage or reduce their contributions in the face of enhanced government support, The result could be taxpayer costs far greater than such proposals initially anticipate. (Estimates prepared for the Pepper Commission indicated that a shift from private to public coverage would increase the cost of one such proposal by 40 percent.)
- **Insufficient Cost Containment.** Tax-incentive based proposals typically encourage the expansion of managed care and other mechanisms to promote competition as a means to contain costs. However, experience indicates that the impact of these measures on the nation's costs will likely be quite limited. Over the past decade, employers have become acutely sensitive to the costs of insurance and many have aggressively tried to manage their employees' care. Reliance on managed care does seem to produce some savings to the purchaser at initiation. But providers remain able to offset one employer's discounts with higher charges to others, and costs continue to rise at rates comparable to those in the fee-for service system.

THE ADMINISTRATION PLAN

The Administration's health care proposal aims both to expand coverage and contain costs. Most significant with respect to coverage, it would provide refundable tax credits to enable low income people to purchase health insurance coverage. In addition it would allow higher income people to deduct insurance premium costs from taxable income. Furthermore, the plan would introduce insurance and other reforms to promote greater and more equitable availability of insurance. Finally, the plan would pursue cost containment through a variety of measures including promotion of more effective insurance competition, insurance networks, managed or coordinated care, and administrative simplification.

Coverage. The Administration's proposal to provide up to $3750 as a refundable tax credit for families with incomes below the federal poverty level, phasing down to a minimum of $375 per family at 150 percent of the poverty level, would address a significant gap in the nation's safety net for the poor. Currently, Medicaid provides coverage for only about half the population with incomes below the poverty level. About a third of the uninsured have incomes below 100 percent of the poverty standard; about half, below 150 percent. The proposed credit would enable many of these individuals to purchase coverage.

However, exactly how many people could purchase adequate coverage with this credit remains an open question. According to an Urban Institute survey, costs of non-group family coverage (through Blue Cross plans) range from about $2000 to $8000 around the country, for families with parents aged 30–89. Further variation exists, based on age, sex and health status of family members. Although the Administration plan proposes measures to limit some of this variation, the adequacy of the plan to guarantee adequate coverage would vary considerably from place to place—a function of state policy in defining coverage, insurers' willingness to provide adequate coverage at the credited amount, and the basic costs and characteristics of the local health care marketplace.

The phasing-down of the refundable tax credit to a minimum at 150 percent of poverty poses a far more substantial barrier to coverage expansion. A family of 3 with an income of $17,000 would receive only the minimum credit or tax deduction under the plan. Even if the cost of coverage were $3750, that means that—*unless a family's employer contributed to insurance premiums*—the family would have to contribute about 20 percent of their income in order to buy insurance protection.

In other words, the minimum credit or deduction somewhat reduces insurance costs; but its impact is so slight that, without participation by their employers, the cost of coverage is likely to be well beyond their means. Currently insured workers may derive some benefit from the deduction, reducing their share of premium costs. But the deduction's impact on price will be too small to make insurance affordable for workers now most likely to lack insurance protection—workers in firms that do not provide it.

The Pepper Commission evaluated a proposal similar to the Administration's that provide graduated insurance subsidies to peoples with incomes up to 200 percent of the poverty level (higher than the Administration proposal's standard for credit

eligibility, but without the deduction above that level). Estimates prepared for the Commission, using relatively generous assumptions about eligibles' participation, indicated that under this proposal, at least half the currently uninsured would remain uninsured, despite the subsidies. Estimates of the impact of the President's plan, developed separately by the Employer Benefits Research Institute and Ken Thorpe of the University of North Carolina find a similar impact—at best—for the Administration's plan.

The Administration plan describes its insurance reform proposals as the means of providing "insurance security" for all Americans. New rules regarding insurers' treatment of preexisting conditions and renewability of coverage would, indeed, secure coverage for individuals now at risk of losing it once they become ill. And proposed changes for underwriting rules and risk sharing would similarly improve access to coverage. In fact, changes of this nature are essential, if the risk-spreading insurance purports to provide is to be returned to the marketplace.

However, while greater risk-spreading improves the availability of insurance, it cannot guarantee its affordability. New rules that require insurers to accept greater risks will expose insurers to higher costs. And, as long as insurance purchase remains voluntary, these greater risks remain the most likely new purchasers of insurance protection. As a result, insurance premiums are likely to rise—reducing rather than enhancing the availability of coverage.

Further, experience with efforts to expand employer provision of insurance suggest that, as long as employer provision of insurance is voluntary, even reductions in insurance costs do little to induce employer coverage. Recent analysis of a New York experiment by researchers at the University of North Carolina and Harvard found that even substantial subsidies increased the proportion of employers offering insurance only 3.5 percentage points. They concluded that, in a voluntary system, "many small firms would not offer their workers health insurance even with subsidies as large as 50 percent to 75 percent of the premium."

As a result, under the Administration proposal, higher income people have "insurance security" only as long as their employers are willing to provide them coverage. For the two-thirds the uninsured with incomes above 100 percent of the poverty level—as well as the currently insured whose employers are already struggling with insurance costs—the plan provides no real guarantee.

Cost Containment. Most Americans now rely on employers to provide their health care coverage. The Administration plan counts on employers to continue playing that role. Recognizing the burden to employers health insurance has become, the plan promotes mechanisms to reduce employer insurance costs. Specifically, by proposing insurance reform, the Administration plan encourages insurers to compete by managing care, rather than avoiding risks; by facilitating insurance networks, the plan alms to reduce small employers' administrative costs and enhance their capacity to negotiate with insurers and providers for lower rates; and by overriding state statutes, the plan aims to expand reliance on managed or coordinated care plans.

These measures, if accompanied by adequate consumer protection, have the potential to reduce some purchasers' insurance costs relative to current levels. However the capacity of these measures to slow the nation's double digit health care inflation is decidedly limited. Research indicates that, unless choice of providers is significantly restricted, managed or coordinated care arrangements have little or no impact on users' health care costs. Furthermore, whatever impact exists, seems limited to a one-time reduction, on establishment of the plan. Over time, even the most successful managed care arrangements experience premium cost increases on a par with the traditional fee-for-service system.

Although the Administration plan might expand small employers' access to managed care arrangements many large employers have already tried, it ignores the fact that large employers are coming to recognize these arrangements are inadequate to contain costs. Large employers who have aggressively pursued managed care—Georgia Pacific, Xerox, Southern California Edison, Chrysler—have come to recognize that on their own, they cannot achieve adequate cost control. Although they would not abandon their role in managing care, they believe it can only be effective within a broader framework that requires all employers to provide insurance and establishes national budgets for expenditures, within which managed care and other providers must operate.

Without such measures, current projections that employer-paid premiums will rise from 7-8 percent of payroll to over 20 percent of payroll by the year 2000 remain a major concern.

Summary. If the standard for evaluating a reform proposal were whether it improved coverage or reduced costs for *some* Americans, the Administration proposal would get relatively high marks. But the proposal falls significantly short of both universal coverage and reductions in health cost increases for the nation. While it

improves coverage for the low income population, it achieves neither coverage security nor cost containment for the vast majority of Americans.

CONCLUSION

In conclusion, most tax-incentive based health reform proposals are limited by their basic premise: that, with a little government help and encouragement, the marketplace can provide all Americans health insurance coverage at affordable costs. The facts are otherwise. Universal coverage and cost containment can only be achieved when government assumes responsibility for building a health care system that guarantees *all* Americans affordable coverage and requires *all* purchasers to participate equally in a system to contain costs.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

[June 9, 1992]

Thank you, Mr. Chairman. I do not have a lengthy statement, since I have commented on this subject at earlier hearings of the committee on the reform issue.

I do appreciate the opportunity to hear from, and to question, exponents of additional major reform proposals. Today's hearing on employer-based approaches is particularly important given that several of the major reform proposals being considered would continue to base health insurance on employment.

I look forward to hearing responses to the criticisms that have been directed at some of these approaches.

As I said at earlier hearings, we seem to be grid-locked at the Federal level, and discussion and debate on the merits and demerits of the major approaches might help build the critical mass of opinion that's going to be needed if we are to move forward on this very major problem.

I look forward to the testimony, Mr. Chairman. I will have some questions.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

[June 17, 1992]

Thank you for convening what I am sure will be another useful hearing on specific proposals for health care reform.

To date I have not been enthusiastic about single payer reform plans of the kind we will hear about today.

At a general level, it seems to me that such proposals assume too easily that many of the most important budget and rate-setting decisions can be taken from the national level, administered from the center, if you will, whether by some new independent national commission or board or by a new Federal agency.

I am skeptical that this can be done efficiently and effectively from the national level in a way that takes into account the great diversity of our health care system and the great diversity and scope of our country. I don't believe that our experience with the Medicare program, insofar as that might provide some indication of how some of these proposals might work, has been particularly encouraging.

Insofar as these proposals rely on global national health care budgets and rate-setting to achieve some specified level of spending, can we be sure that resources will be allocated efficiently or to necessary and high quality care. To be sure, we will be able to say with confidence that we are only going to spend X number of dollars, but how do we know, for instance, that global budgets and rate-setting will squeeze out of the system only the unnecessary care we hear so much about and will not squeeze out necessary care?

The call for large new Federal resources also concerns me. Senator Kerrey's plan, for instance, would be paid for with increases, some substantial, in at least ten different Federal taxes. In fairness, I am sure that in Senator Kerrey's plan other outlays by individuals and companies would go down and perhaps the plan contemplates an over-all reduction in health care spending.

Nevertheless, proposals for such substantial increases in Federal tax revenues ought to be looked at carefully, it seems to me. Once virtually our entire health care system gets linked with Federal taxes, the system is likely to become a political football, kicked around during the budget cycle just as Medicare is now.

Mr. Chairman, I will just conclude with one other point. Somehow, there seems to be a particularly strong temptation among advocates of single payer approaches to fall in love with the way other countries do it—a particularly strong temptation to tell us that we only need to look at Canada, or look at Germany, or look at

France or the Netherlands for examples of better ways to organize a health care system.

I'm afraid I have to remain a skeptic that much of what we hear about these other countries will tell us very much about how we should proceed here in the united states. In fact, I'm not even sure that some of the simple indicators that are constantly thrown up at us are particularly meaningful once you take into consideration demographic differences, behavioral differences between populations that have great relevance for health care status and the problems the health care system must solve, and the political and cultural differences that one of our witnesses will discuss today. Usually, the kinds of comparative generalizations made aren't really based on rigorous cross-national comparisons.

That is all I have for the moment, Mr. Chairman. I look forward to the testimony.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

(July 18, 1992)

Mr. Chairman, I want to start by commending those members of this committee and of the Senate and House who have developed health care reform plans for their efforts to craft solutions for what we all realize is a seriously flawed system. I believe that all of these plans are serious efforts to improve health care for our citizens.

Nevertheless, as I noted in the statement I submitted for the hearing record yesterday, I have not been enthusiastic about single player reform plans of the kind we heard about yesterday. Neither have I been enthusiastic about play or pay approaches.

It seems to me that we would run great risks by implementing such reform plans. It seems to me that they have conspicuous deficiencies which should make us cautious about implementing them.

As I noted in my statement for yesterday's hearing, I think the notion that we can administer, efficiently, fairly, and effectively, through a commission, independent board, or federal agency, the reimbursement for virtually the entire health care system, suffers from the failing the Greeks called *Hubris*.

Play or pay plans, some of which rely on such reimbursement features, raise the added risk that many small businesses will not be able to afford the play or pay requirement, and thus we may see more small business failure, downward pressure on the wages of small business employees, or slowed creation of small businesses. Perhaps such plans can be made to work in the environment of individual states, and perhaps individual states should be given latitude or encouraged to try such approaches. But I think we should be very cautious before imposing them from the Federal level.

Obviously, we run risks by *not* pursuing reforms in the health care system. The longer we delay taking steps to improve the system the larger get these risks. The high, and rapidly increasing, costs of health care are hurting many of our citizens and doing great harm to American businesses.

I find myself, therefore, more in sympathy with the kinds of approaches we will hear about today which are predicated more on active consumer involvement and consumer choice than on top down, national budgeting and rate-setting methods.

Certainly, these approaches are not without flaws. And I am sure we will hear about those flaws today.

But it seems to me we can greatly improve our health care system, and run less of a risk that we make a bad situation worse, which we are certainly capable of doing, by trying approaches closer to those we will hear about today than the other types currently under consideration.

PREPARED STATEMENT OF PAUL F. GRINER

The American College of Physicians (ACP) is pleased to have this opportunity to present our recommendations on comprehensive health care reform. With more than 76,000 members practicing internal medicine, the College is the nation's largest medical specialty society. I am Dr. Paul F. Griner, President-Elect of the College and Chairman of the Access to Care Steering Committee. I am General Director of Strong Memorial Hospital in Rochester, New York.

OVERVIEW

From our perspective as a professional society of physicians whose goal is excellence in medicine, we see a system failing all who are a part of it—patients, physicians and other health professionals, purchasers, and insurers. Most of the problems

have been well documented: 35 million or more Americans without health coverage, excessive utilization of high technology existing side-by-side with substandard care, spending that increases at astonishing rates without commensurate gain in health status, a system that promotes acute care at the expense of preventive services and technology-based subspecialty care at the expense of primary care. As practitioners, we feel the fear of uninsured or underinsured patients at the prospect of severe illness, and appreciate the dilemma of those who feel themselves locked into jobs for fear of losing their health coverage. And we confront every day the crushing bureaucratization of a system that diverts time, energy, and resources away from patient care, frustrating the ability of physicians and patients together to treat illness.

As we have sought solutions, three aspects of our current system appear particularly troubling. First, it promotes a dichotomy and conflict between the private and public sides of the system. Public programs lacking a powerful constituency are underfunded, and the total system suffers from enormous and unnecessary administrative complexity and cost. Second, benefit packages are comprised of circumscribed lists of covered services that reflect more the needs of the payers of health care than those of the patients. Third, we have not implemented effective cost control strategies, which are necessary both to make the system affordable and to reverse the intrusive regulatory burden.

America urgently needs comprehensive health care reform. ACP believes that universal access to care can be achieved only through system-wide reform in the organization and financing of health care. Our position will outline a national policy to achieve that reform through four central elements.

—*Assuring access to care.* First, we propose a universal insurance system that relies on private and publicly sponsored insurance plans. All public programs of health care would be consolidated, so that everyone is guaranteed insurance coverage, funded through a combination of private premiums and public revenues.

—*Assuring High-Quality and Comprehensive Health Care.* Second, we propose that all medically effective services be covered when they are appropriate to a particular patient, rather than excluding a necessary service because it is not in a predetermined package of benefits.

—*Controlling Costs.* Third, we propose a national health care budget with a mixture of centralized and de-centralized mechanisms to influence the price, volume, supply, and demand for health care services.

—*Promoting Innovation and Excellence.* Fourth, we propose measures to enhance the crucial institutional underpinnings that sustain excellence in medical care—research, education, effective information management and an improved environment for the practice of medicine.

ASSURING ACCESS TO CARE

The ACP proposes a universal insurance system with two streams of financing, one private and one public. Everyone would have health care insurance. Covered benefits would be the same for everyone: all medically effective and appropriate care. Public plans that result in a second class of care for segments of the population would cease to exist.

We envision an integrated system in which employers and government would sponsor and financially support a range of insurance plans, which in turn would offer alternative practice arrangements, from traditional fee-for-service to a variety of organized delivery systems. Patients and providers would not perceive any distinction between employer-sponsored and publicly-sponsored plans, because there would be no difference except for the source of financing. We reject proposals that relegate the "public plan" to second-class care.

Our plan is designed to encourage employers to provide insurance by taking steps to help ensure that coverage is more affordable and premiums more predictable. To encourage private, employer-sponsored plans, we propose phasing out employer responsibility for retirees and employees over 60, and providing public coverage for all patients who face catastrophic medical costs. The goal is to establish a healthy competition between the public and private sides in which employers can choose to provide health insurance through a public program or private insurance. However, we seek to avoid conditions where employers opt to "pay" because of high premium costs to "play."

Insurance Reform

Our support for an insurance-based system is grounded on our belief that it will foster a wide range of practice arrangements of benefit to patients and providers. We also believe in decentralized administration, under national criteria. This should

not be interpreted as support for the way insurance companies now do business. Substantial reform is needed. Legislation such as that sponsored by Senator Bentsen and others contain many of the reforms that we support, such as elimination of exclusions for "pre-existing conditions," adjusted community rating and guaranteed issuance. These requirements must be in the context of comprehensive reform. Without cost containment, for example, new requirements for the insurance industry might simply increase costs for the majority of small employers and their employees.

Competition among insurance plans under the ACP approach would be based on price and value offered to corporate and government purchasers, not on the basis of benefit "packages," risk selection, or underpricing of provider services. Streamlining administration and other efficiencies might result in lower premiums. Providing better value through provider selection and organization might make other plans competitive even at a higher price.

There would be strong incentives for plans to organize delivery systems for effective and efficient management of care. Quality improvement and cost reduction could be achieved through primary care networks, multi-location group practices, and new organizations and financial relationships between hospitals and their medical staffs.

Underserved Populations

Even with universal insurance, there will still be underserved rural and urban populations. We must expand the public health system and consider innovative ways to address the geographic maldistribution of providers. Capital will be needed to develop or upgrade facilities and equipment. More effective integration of health services at the regional level will be required.

Meeting the needs of dispersed rural populations is especially challenging. ACP members in rural practices are committed to their patients. to their communities, and to providing the highest quality of care. This is clearly the kind of medicine we want to foster within our health care system. Physicians point to inadequate reimbursement rates, federal regulations that do not take into account the realities of rural practice, and the closing of small hospitals as barriers to recruiting and retaining health care professionals in rural areas. In a reformed system, we must build in incentives to bring dedicated professionals to underserved areas, and keep them there.

ASSURING HIGH-QUALITY AND COMPREHENSIVE HEALTH CARE

Benefits reform is needed now. The ACP proposes a benefits determination process that is patient-specific and medically oriented. It provides all Americans with care that is both effective and appropriate to their needs. We object to predetermined basic benefit packages that are designed to limit risk without adequate attention to the needs of patients. Health services for both publicly- and privately-sponsored plans should be identical.

Benefits determination should be structured to address whether a service is effective, valued by society, appropriate for a particular class of patients or clinical circumstances, and beneficial and appropriate for the particular patient.

This process should provide reimbursement for all services patients require. Additional services such as cosmetic surgery or hospital amenities could be paid for out-of-pocket or through supplemental insurance, neither being tax deductible expenses. Finally, because our plan calls for all medically effective and appropriate services to be covered, individual state legislative mandates for coverage would be eliminated.

Quality Assurance and Utilization Management

A reformed system must include a restructuring of external oversight and quality of care. An end to the crushing regulatory intrusion that dominates practice today would be a major trade-off for some of the constraints that will come in a reformed system.

Time-consuming, intrusive case-by-case review has not been shown to improve the quality of care but has contributed significantly to mounting frustration and dissatisfaction within the profession and among patients.

Under a national health care budget, organizations that are the locus of clinical care such as group practices or hospitals will have incentives to provide cost-effective, high quality care. Practice guidelines and profiling will help determine whether individual treatments are appropriate and whether overall patterns of care fall within guidelines.

Malpractice Reform

We propose substantial reforms for liability determination, as well as strengthened efforts by the profession and licensing authorities to monitor physicians and correct problems. Tort reform will set the stage for the journey back from defensive medicine, but it will not be enough. We must rethink the entire process of liability determination, including a role for innovative administrative processes as formulated by the AMA/Specialty Society Medical Liability Project. Liability legislation introduced by Senator Hatch and others contains several of the tort reforms that would help get the system back on track: a cap on awards for non-economic damages; elimination of joint and several liability; modifications to statutes of limitations; and limits on attorney contingency fees.

Despite the fact that medical liability premiums for internists are among the lowest compared to other specialties, a survey conducted by ACP revealed that our members rank medical liability close to the top of those issues that must be addressed to achieve a better health care system. This seems to indicate the pervasiveness of liability in clinical decision making, resulting in additional costs to the system and impacting the physician/patient relationship. The problem is often noted by rural physicians who feel especially vulnerable without the back-up of other specialists in their communities.

CONTROLLING COSTS

Cost control mechanisms are essential elements of our reform proposals. The United States can no longer sustain the current level of growth in health care expenditures. As health care takes an increasingly large portion of the nation's resources as well as individual income, a broad consensus is developing that health care reform must include cost control.

A National Health Care Budget. We propose a national health care budget that sets limits on total spending and drives a series of measures to address price, supply and demand for services.

The budget would be set at the national level, taking into account such variables as the changing health needs of the population (including its aging), new technology, and general inflation. A national commission would recommend the budget, which Congress would approve. The commission, in consultation with state authorities, would develop a budget for each state based on its population and disease burden. Operating within state health budgets, the States may choose to establish or recognize regional authorities that would further control health care spending within the state.

Managing Price: Insurer/Provider Negotiations. States would be required to establish mechanisms for the publicly and privately sponsored insurance plans to negotiate with physicians, hospitals, and other health care providers. Using research-based methods for valving services such as the RBRVS and DRGs, providers would agree on conversion factors that would set a uniform fee schedule for each year. Qualified managed care organizations could negotiate an overall budget that is based on enrollment, age distribution of enrollees, and expected morbidity.

Payments to providers under the various fee schedules, multiplied by expected utilization of all services, could not exceed the state's allocation under the national health care budget. A state health care agency would monitor utilization patterns by service category and study variations from predicted use. The state (or regional agencies within the state) would have the authority to take steps to stay within the state's allocation of the health care budget.

If a state's health care expenditures exceed its budget allocation, even after corrections to the conversion factor, health care spending would not come to a halt. Expenditures that could not be attributed to unanticipated illnesses or other factors would trigger reductions in the fee schedules or other remedial action for the following year. The national budget is a device to introduce fiscal discipline and evaluate whether expenditures reflect expectations and goals; it is not a mechanism to cut necessary care.

A great deal of cooperation among providers will be necessary under a national health care budget of this kind. Providers will have to create a climate of clinical decision making in which unnecessary care is not tolerated.

Managing Supply: Regulatory Approaches. The incentives of the current system must be changed to correct the maldistribution of health resources that include manpower, technology, and facilities. The appropriate mix of economic and other incentives may be more important in determining the quality and cost of a reformed system than whether its basic structure is employment-based, publicly financed, or marketplace-based. The problems are well known: hospitals a short distance from one another with duplicative high-technology services, free-standing clinics that

skim away high revenue generating procedures, and physicians that are attracted to specialties that are in oversupply and in areas already well or over-served.

We must change our thinking about regulation from the "micro" level of the individual physician patient encounter to the "macro" level that deals with supply or inputs into the system. We propose that states and communities, under federal guidelines, establish targets for the supply of health resources, such as physicians, hospital beds, and major technologies, and introduce controls to help avoid excessive supply and utilization of these resources.

Of special urgency is the necessity to increase the number of primary care and generalist physicians. The output of our training programs must change from the current distribution of 35 percent generalists and 65 percent specialists to a balance in the profession as a whole. To achieve this will require major changes in how the country educates medical students and residents and how they are paid once they enter into practice. Fees must be substantially augmented for evaluation and management services that form the core of practice for generalists, and for physicians practicing in underserved areas. Finally, the practice environment must be improved for generalist physicians if the infrastructure for personal health care is to be sustained in this country. Freedom from intrusive oversight and enormous administrative burdens are absolutely essential.

CONCLUSION

There are important and practical details to be developed that will be included in the final ACP proposal. We are fully committed to reform of the health care system and hope our comments today are useful to the Committee as it moves forward on this shared goal.

PREPARED STATEMENT OF GEORGE HALVORSEN

Good morning Mr. Chairman and members of the Committee. My name is George Halvorsen and I am President and CEO of Group Health Inc., an HMO based in Minneapolis, Minnesota. We currently have more than 320,000 members and in addition to commercial enrollees, our members include Medicare and Medicaid eligibles as well as federal employees, retirees and their dependents. To provide care we contract with more than 1500 primary and secondary physicians, we have 55 medical centers or clinics and we contract with 21 hospitals. I have recently been asked to serve on the Minnesota Health Care Commission. This 25 member task force is charged with implementing the state's newly enacted Health Right plan and with devising a cost control strategy for the state which reduces costs 10 percent each year for the next 5 years.

I am here today as Chairman elect-of the Group Health Association of America, Inc. (GHAA). GHAA is the nation's oldest and largest trade association for health maintenance organizations (HMOs) and similar managed care systems. GHAA member plans enroll most of the 38.6 million people nationwide who are members of HMOs.

This Congress has before it a daunting challenge—to make changes in a health care system to assure that the tens of millions of people in this country who lack health coverage or those who lack adequate coverage, get access to needed services. If this weren't enough, the reforms you endorse must also provide that coverage is affordable, both to the employee and the purchaser, be it a private employer or the government. You must also assure quality of care. Finally, you must make changes which restructure incentives and aid in cost containment. According to a recent article in the Journal of American Medical Association, health care spending is doubling every five years and could reach $1.4 trillion in 1996.

I am here today to talk briefly about the advantages of HMOs and managed care. The single most important point I wish to make today is that HMOs and other similar managed care programs must be recognized in any national health care reform proposal. Programs limited to cost reimbursement alone, whether a Canadian model or any other, eliminate the incentives we give to consumers, providers and purchasers. The rational, balanced incentives found in the HMO delivery system should be a model. It would be a shame if this country did not learn a lesson from other countries that have created health care systems that have no role for HMOs or lack sufficient incentives for their continued existence. In fact, many of these countries are now coming to GHAA and to our member HMOs asking how they can restructure their systems so that HMOs can develop and have effective participation.

HMOs have enjoyed the bipartisan support of Congress and the past five Administrations. They are currently featured in managed care provisions of pending health care reform legislation sponsored by Democrats and Republicans alike. And in fact,

some of these health care reform proposals attempt to create incentives for HMOs and managed care systems. Senator Chafee's bill is an excellent example; it encourages employers to use HMOs and managed care by providing a tax credit. And legislation introduced by Senators Bentsen, Rockefeller, Mitchell and Riegle also seek to remove a serious barrier to managed care growth through federal pre-emption of state anti-managed care legislation. GHAA supports using the tax system to encourage the purchase of cost effective health coverage. We also support the goal of making consumers aware and responsible on issues of cost. A tax based approach alone however, does not address the issue of the uninsured.

Simply, we offer many advantages to members and their employers. HMOs have a well established track record in providing affordable, quality, cost effective and comprehensive health services. This is demonstrated by the growth in enrollment in HMOs. In the past year, national enrollment grew by 2 million people. In many states, HMO enrollment is significant. In California and Massachusetts, one in every three people are enrolled in an HMO. Minnesota, Oregon, Arizona, Hawaii, Wisconsin, Maryland, Colorado and Connecticut, all have more than I in every five people who are members of an HMO. HMOs also enroll more than 2 million Medicare beneficiaries, 1 million Medicaid eligibles and 27 percent of the 9 million federal employees, retirees and their dependents who participate in the Federal Employees Health Benefits Program.

We are able to provide affordable and comprehensive health care because of the way incentives are structured. Through the integration of financing and delivery of health care to an enrolled population, HMOs avoid the perverse incentives of the traditional fee for service system which rewards more care with more money when more care is not necessarily better care. For example, in the fee for service sector, the more tests performed, the higher the income of the provider.

Access to care, emphasis on prevention and early intervention and the coordination of health care services in the HMO are not only cost effective, all lend themselves to a quality of care that is enhanced. Many studies back this up, showing quality of care in HMOs that is equal or superior to that found in the fee for service sector. And in fact, the only health providers who have their quality of care reviewed for ambulatory care are HMOs with Medicare risk contracts.

HMOs have incentives in place to provide care to the patient in the most appropriate and cost effective manner—often providing care in an ambulatory setting. HMOs are well known for their lower utilization of inpatient days—established HMOs provided 316 days per 1,000 enrollees under 65 versus a national average of 499 days per thousand in 1989. HMOs also have a lower rate of discretionary surgery than the fee for service sector, but an equivalent rate on non-discretionary surgery, according to a recent RAND study.

Our ability to be cost effective means that a comprehensive benefit package can be offered and allows minimal or nominal cost sharing. It is not enough to offer benefits, they must be affordable.

Much attention has focused on the cost effectiveness of HMOs, particularly compared to the premium increases in the indemnity market. HMO premiums have generally increased at a much slower rate than indemnity insurance. For 1991, according to a Foster Higgins study, employers paid 14.7 percent per employee per year less for HMO coverage than for traditional health insurance. Unfortunately, a direct comparison of HMO premiums with insurance premiums does not tell the whole story. In the last several years, the personal cost to the individual or family with indemnity coverage through increasingly high deductibles and coinsurance, has increased their barriers to care.

At the same time, HMO copayments have remained low, encouraging access and appropriate use of health care services. HMOs focus on preventive and primary care. Nominal amounts are charged for a primary care visit—the average office visit in 1991 cost $5. Most HMOs provide a prescription drug benefit, usually with a $3–5 copayment per prescription. For many preventive services, including well-baby care and immunizations, HMOs require no copayment.

Administrative costs have also received much attention. Well-run health care systems must perform certain basic administrative functions—they must collect revenues/premiums, pay health care providers, and manage utilization. With most health insurance—indemnity insurance and government-financed coverage such as traditional Medicare, an individual purchases insurance from one company and gets health care services elsewhere. Because HMOs combine the two in one company, it is misleading to compare HMO administrative costs directly with those of programs that do not directly provide and finance health care.

GHAA data show that HMOs devoted 9.4 percent of their total 1989 expenditures to non-medical administrative costs. However, larger HMOs such as Kaiser Foundation Health Plan, which spent just 2.5 percent on administrative costs in 1990, and

Group Health Cooperative of Puget Sound, which spent 5.1 percent the same year, have reduced the amount spent on administrative costs.

HMOs have a number of natural advantages that explain these lower administrative numbers: HMO administrative systems are more streamlined; proper utilization management is part of HMO design—not an add-on; and HMO cost sharing is simpler to administer.

In summary, HMOs provide comprehensive, cost effective, quality health care. Their advantages impact both the member or patient and the purchaser. It is crucial as you consider the many different approaches to restructuring the health care sector to provide care to the uninsured and get control of escalating costs, that you consider the impact on HMOs and create an appropriate role, in fact encourage, managed care.

PREPARED STATEMENT OF SENATOR HATCH

[June 9, 1992]

Mr. Chairman, I commend you for your leadership in scheduling these much needed hearings so that we can move this debate toward some constructive end during this session. This is a balanced and learned panel you have brought together today, and I look forward to hearing their insights.

The prevalence of today's employer provided health care coverage is largely the result of several factors: wage and price controls during World War II that led to the use of health care benefits as part of non-cash for wage replacement; following the war, pressure from labor unions to include health care benefits as a bargainable issue; and federal tax incentives such as the "employee exclusion" and "business expense deduction." The result is that nearly 139 million Americans have employer-based health insurance coverage today. That's the good news.

However, the bad news is that the cost of health care rising at three times the rate of inflation has taken its toll. We know that the number of medium and large-sized firms that cover the full cost of health insurance for workers and their dependents is dropping. Employers cannot afford continual premium increases and have been cutting back on the benefit plans they offer. Workers with insurance are bearing a larger burden in terms of cost-sharing and higher deductibles.

We have heard testimony in this Committee before that many small businesses would like to offer health insurance to their employees, but are prohibited by the cost. Almost 90 percent of all firms that have fewer than 20 employees are operating on very small profit margins. For example, a study done by Catherine McLaughlin of the University of Michigan found that about one-quarter of the small businesses surveyed that did not offer health insurance were grossing less than $30,000 per employee. After subtracting salary and overhead costs, this would not appear to be an amount that could sustain the cost of providing health insurance.

I know that the Employee Benefit Research Institute has estimated that in 1988 nearly 50 percent of uninsured workers were either employed or self-employed in firms with fewer than 25 employees. So we have in the end a difficult and complex problem of how to extend coverage to this group of workers in a manner that is affordable for the workers and for small businesses.

I look forward to hearing from our panelists.

PREPARED STATEMENT OF ORRIN G. HATCH

[June 17, 1992]

Mr. Chairman, I commend you for your leadership in convening this series of hearings on health care reform.

Last week, the Finance Committee examined the employment-based approach to insurance that builds on the existing health care system in America. But, today we will focus on a very different approach that would "wipe the slate clean" and put in place a very different system of health care delivery.

Our nation is facing a crisis in health care. Our nation looks to Congress for leadership—leadership that can ensure quality health care to the millions of Americans who now go without the basic health care enjoyed by the majority of our citizens.

I believe, however, that the health care system we develop in America must be based on what is best in our present system and what our citizens tell us are the essentials of any system, including the freedom of choice.

I believe we should avoid what call tee "grass-is-greener-on-the-other-side-of-the fence" attitude. Proponents of single-payer systems seem to push us toward a radical transformation of our existing health care system.

Clearly, major changes are needed, but can single-payer systems preserve what is best and uniquely American? Are highly regulated single-payer systems compatible with our American culture and values? Will they work with our mix of health care providers and medical education training system?

I am troubled by the complex decisions about medical resource allocations being made, directly or indirectly, by the Federal Government, far removed from the levels where services are actually provided. I do not understand why this would be preferable to individual doctor-patient decision making.

While we can learn from the successes and mistakes of our international colleagues, I am skeptical about whether we can simply superimpose a foreign health care model on American citizens. Our economy is different, our political institutions are different, our demographics are different, our culture and values are different, and our needs are different.

Smoking costs our nation $52 billion annually, with drug abuse following close behind at $44 billion. Over 65,000 Americans are admitted to hospitals annually for gunshot wounds. Gunshots and other assault injuries cost Americans $4.4 billion each year. Over one million American women seek medical care every year for injuries caused by domestic beatings. The total annual cost of sexually transmitted diseases in our country, excluding AIDS, is over $3.5 billion. The cost of AIDS in the United states is projected to be between $5 and $13 billion in 1992. These indicators of our culture and needs are far different, I believe, from the culture and needs of our neighbors to the North.

Mr. Chairman, I have come this morning to learn and to listen to the testimony of these distinguished panelists. I look forward to this hearing. Thank you.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

(June 18, 1992)

Mr. Chairman, this is an important hearing. I look forward to exploring ways that our current federal or state tax laws might be modified to help more individuals and their families obtain health insurance coverage. About one in ten Utahns are uninsured—and we are all familiar with the numbers nationwide.

While I must state my strong preference for market based reform solutions up front, I am also interested in learning how such solutions can expand access to all Americans, control costs, and maintain quality.

The current tax treatment of employer-paid health insurance premiums has aided the expansion of employer-based health care; but, unfortunately, it has also contributed to health care inflation. Individuals shielded from the true costs of health care by these subsidies have less incentive for cost containment.

We heard testimony last month in this committee that one way to control health care costs would be to replace the current open-ended tax subsidy to employer-provided group insurance with refundable tax credits. I am interested in learning more about this approach from our panelists today. I know that the Heritage Foundation has such a proposal, and I look forward to hearing from them.

PREPARED STATEMENT OF DAVID U. HIMMELSTEIN

Mr. Chairman, Members of the Committee, thank you for the opportunity to testify here today. My name is David U. Himmelstein. I am a physician in the practice of internal medicine in Cambridge, Massachusetts, and Associate Professor of Medicine and Director of the Center for National Health Program Studies at Harvard Medical School and the Cambridge Hospital. I also represent here today Physicians for a National Health Program, an organization of nearly 5,000 physicians throughout the nation which advocates a universal, comprehensive, publicly administered, single payer national health program.

I am pleased to be able to enthusiastically endorse the health care reform legislation recently proposed by Senator Wellstone. This legislation is the only fully satisfactory health care reform proposal offered in the Senate in the past two decades. Unfortunately, the alternative proposals to Senator Wellstone's all would make deleterious concessions to insurance companies and other powerful special interest groups. Such concessions would undermine the effectiveness of health care reform, leading to unnecessary cost increases, and compromises in the quality of care.

While I will not review the full litany of problems afflicting our health care system and the debate over reform, let me point out a few disturbing trends that have received relatively little attention. First, for the past decade there has been a steady decline in the number of Americans covered by private insurance. Ten million fewer people have private health insurance today than in 1982. At the same time, the

total premiums collected by private insurance companies have gone up more rapidly than ever. These trends are illustrated in Chart 1. As a result, even record expansions of public programs, such as the one-time Medicaid expansion that took effect during 1990, have failed to keep pace with the rising number of the uninsured.

Second, even those *with* coverage often have grossly inadequate policies. For instance, five million young women have insurance policies that exclude maternity care. Despite Medicare, seniors now pay more than 18 percent of their total income for health care costs, a 50 percent increase over the past decade. Among insured Americans under the age of 65, 12 percent of those with a serious or chronic illness experience major financial problems due to illness during any given year, and 15 percent are unable to afford drugs, physical therapy or other needed care. Hence, reform must address the problems of those who currently have coverage, as well as the uninsured.

Third, we cur · ntly spend vast sums on health care that actually worsens health. For instance, ac. ·rding to a Rand Corporation study, 14 percent of coronary artery bypass surgery is clearly unnecessary; it does patients more harm than good. Indeed, the Rand researchers found six patients who had normal preoperative coronary angiograms, i.e., no disease in their coronary arteries, but underwent surgery nonetheless. The record for many other types of operations is even worse. In addition, our duplicative investments in technology sometimes actually worsen the quality of care. For instance, the American College of Surgeons has suggested guidelines for the minimum volume of complex procedures that a hospital should perform annually in order to develop and maintain competence. Yet, more that a third of California hospitals that perform open heart surgery have dangerously low volumes that raise both death rates and costs. Similar patterns of duplicative facilities leading to lower levels of competence and worse patient outcomes are evident for transplants and other complex and expensive procedures.

Fourth, a campaign largely funded by insurance firms and pharmaceutical manufacturers (using money collected from patients as part of their health care costs) has misportrayed Canada's experience. Canada's system has indeed controlled health spending (Chart 2). Moreover, as compared to Americans, Canadians receive more physician services, more hospital care, and even more of many high technology procedures such as transplants (Chart 3). All of this while spending almost $1,000 less per capita on health care. In comparing our care and Canada's, we should keep this enormous cost differential in mind. A Canadian-style system in the U.S. would be Canada deluxe; with no need for any waiting lists or shortages of any kind for the foreseeable future. For any given level of health spending, the Canadian approach yields much more care and much less paper.

Fifth, while we are denying needed care to millions of Americans, we have a surplus of medical facilities, equipment, and personnel. Indeed, much health policy over the past two decades has focused on the oxymoronic task of rationing this surplus. The result has been the development of a huge health care bureaucracy whose principal concern is keeping sick patients away from empty hospital beds and idle doctor's offices.

My own research, along with my colleague Dr. Steffie Woolhandler, was the first to document the growing toll that such bureaucracy extracts from American medicine. Over the past two decades, the number of health care administrators has grown four times as rapidly as the number of physicians or other health personnel (Chart 4). Insurance company overhead now consumes nearly 1 percent of the Gross National Product in our nation (Chart 5). Moreover, the insurance industry inflicts enormous paperwork burdens on hospitals and physicians (Charts 6 and 7). In the twelve months between March, 1990 and March, 1991, American hospitals added 98,000 additional managerial and clerical personnel. Meanwhile, the number of nurses declined by 61,000, the number of physicians employed in hospitals decreased by 9,000, and other clinical professionals decreased by 20,000 (Chart 8). The General Accounting Office has estimated that a Canadian-style national health program could eradicate much of this administrative waste, saving enough on paperwork reduction to cover all of the uninsured and improve coverage for the underinsured without any increase in total health spending. We think the GAO estimate is conservative.

Senator Wellstone's proposed legislation would realize these massive administrative savings, and use them to provide much needed care. This legislation would also greatly strengthen health planning, allowing the elimination of much of the wasteful duplication of technology that currently drives costs up and quality down. Moreover, it would provide an effective framework for hard bargaining with the drug and equipment industries which currently sell their products at inflated prices in the United States. Indeed, drug prices are, on average, 38 percent lower in Canada than in the U.S. (Chart 9), even though most drugs in Canada are purchased from U.S.

pharmaceutical firms. The chart also shows that the multiple payer health care systems of Holland and Germany have drug prices as high as in the U.S., because such systems lack the leverage to negotiate prices with drug firms.

No alternative to a single payer system can capture all, or even most of the administrative savings of the single payer approach. Pay or play proposals would fail to pare the wasteful insurance company overhead costs, and might even increase them. For example, half of the state revenues to subsidize premiums of workers collecting unemployment under Massachusetts' pay or play law have been eaten up by John Hancock's overhead costs. Even implementing the so called "smart card" to standardize health care billing and paying would achieve only very modest savings on health administration, at most one-seventh of the savings achievable under a single-payer system. Hospitals would still have to maintain elaborate internal accounting apparatuses to attribute costs and charges to individual patients. Moreover, the smart card approach would do nothing to lessen the burden of utilization review that currently accounts for a significant proportion of physician and hospital administrative expense. In contrast, the single payer approach abolishes the need for such case-by-case utilization review and other micromanagement of clinical practice, because a single payer system controls costs and utilization through the enforcement of overall global budgetary limits.

Managed care approaches similarly offer little hope of reducing health care bureaucratic costs. HMO's are as administratively costly as indemnity insurers (Chart 10). As shown in Chart 11, a single managed care program in New Jersey that covers 110,000 persons employs 18 full-time nurse reviewers, 5 physicians, 8 provider recruiters, 15 sales representatives, 27 service representatives, and 100 clerks. These personnel contribute nothing to clinical care, besides the harassment of patients and providers.

Unfortunately, neither Senator Kerrey's bill, nor the legislation offered by Senators Daschle and Wofford would create a true single payer system with the advantages that I have outlined. Senator Kerrey would have the government collect all health care dollars, an important advance over the current system. But he would then disburse those dollars through a limited number of private insurers in each state. Since even the most efficient private insurer has overhead costs four to five times higher than those in Canada's national health program, this structure assures the waste of more than $10 billion each year which could be devoted to providing needed care under a true national health program. Moreover, the Kerrey plan would likely force most Americans into large managed care organizations which severely restrict patients' freedom to choose their provider. In contrast, Senator Wellstone's bill would assure a completely free choice of doctor and hospital to every American. The Kerrey bill would also make the payment of hospital global budgets unnecessarily complex, adding yet more administrative costs.

Senator Daschle and Wofford's bill, like Senator Kerrey's, would allow a prominent place for for-profit managed care organizations, which are really just insurance companies in a different guise. Moreover, Senator Daschle and Wofford's legislation would allow private insurance coverage duplicating the public program. Failure to ban competing private insurance would require the perpetuation of the costly bureaucracies that administer and deal with such programs, and would continually endanger the adequacy of funding for the public program. Private insurance would only be attractive if the public coverage were inadequate, assuring massive insurance industry lobbying to undermine the public program. Allowing wealthy Americans to buy out of the public system would erode the support of our most powerful citizens for adequate public funding of the national health program.

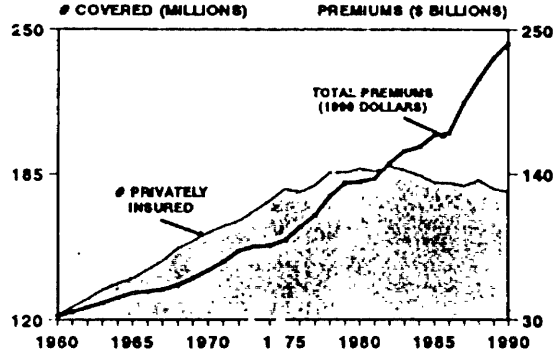
In summary, every compromise to the single payer approach brings with it either added costs or decreased care. As shown in Chart 12, multiple payer systems such as those in Germany and the Netherlands are, without exception, far more administratively costly and complex than single payer systems. As a result, multiple payer systems can only achieve cost containment through mechanisms such as limiting the number of non-physician health personnel (Chart 13), and paying these few personnel extremely poor wages (Chart 14). Thus, adopting the German style of cost containment for the U.S. would imply laying off several million clinical personnel now employed in hospitals (while maintaining most of the administrative jobs), and cutting the wages of the remaining health work force by more than 30 percent.

I want to close with some happy news. A single-payer national health program enjoys extraordinarily broad support among the American people. While the powerful insurance lobby vigorously opposes such reform, two-thirds of the American people consistently support it. Indeed, surveys of Americans and Canadians have found remarkably similar attitudes towards health care in the two nations (Chart 13). Canadians overwhelmingly support their current national health program, and Americans clearly want a similar reform. Unfortunately, our politicians have been far less

responsive to the desires of the American people than Canada's political establishment has proven to be.

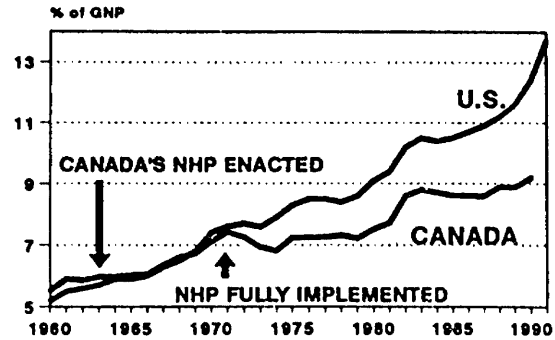
For seventy years we have pursued patchwork reforms of health care in this nation, rejecting national health insurance. During that period every other developed nation has enacted programs assuring universal coverage, and effectively containing costs. Several of these efforts in other nations, especially the Canadian experience, offer useful guides to a successful program. Let us at last implement a single payer national health program that can harness the extraordinary resources for health care available in our nation to provide the highest quality care for all Americans at a cost that we can afford.

CHART 1 - NUMBER OF PEOPLE WITH PRIVATE INSURANCE AND TOTAL INSURANCE PREMIUMS, 1960-1990



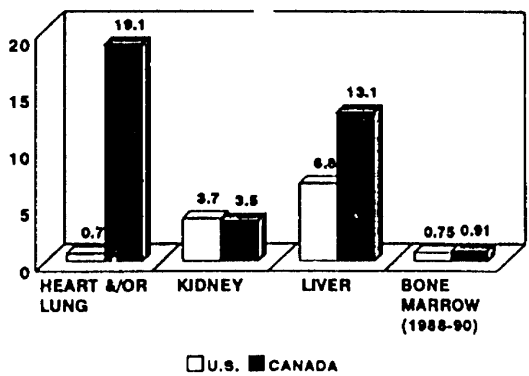
SOURCE: HIMMELSTEIN, WOOLHANDLER, WOLFE - TABULATIONS FROM HIAA/NCHS DATA

CHART 2 - HEALTH COSTS AS % OF GNP:
U.S. & CANADA, 1960-1991



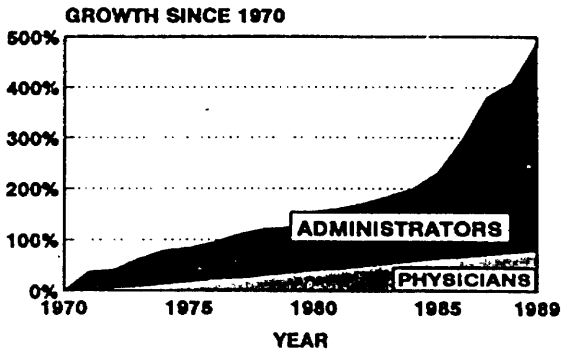
SOURCE: STATISTICS CANADA & NCHS/COMMERCE DEPARTMENT

CHART 3 - TRANSPLANTS, U.S. AND CANADA, 1988
TRANSPLANTS PER 100,000 POPULATION



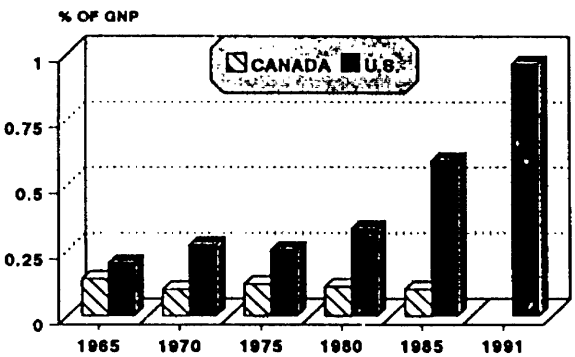
SOURCE: OECD 1991 & ANN INT MED 1992;116:507

CHART 4 - GROWTH OF PHYSICIANS & ADMINISTRATORS 1970-1989 (1970=1)



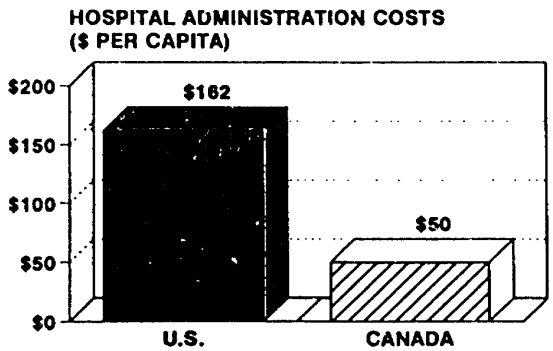
source: Statistical Abstract of the U.S. & NCHS

CHART 5 - INSURANCE OVERHEAD AS A % OF GNP U.S. v. CANADA, 1965-1991



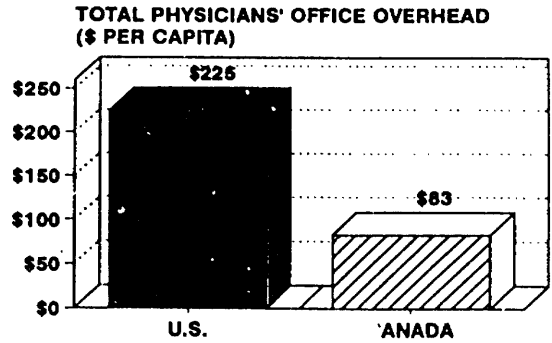
SOURCE: STAT CANADA & NCHS/COMMERCE

CHART 6 - HOSPITAL BILLING & ADMINISTRATION UNITED STATES & CANADA, 1987



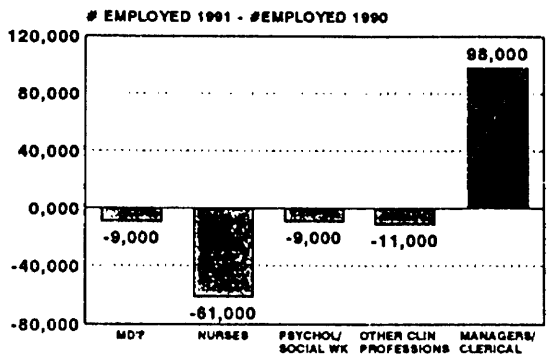
SOURCE: WOOLHANDLER/HIMMELSTEIN NEJM 1991; 324:1253

CHART 7 - PHYSICIANS' BILLING & OFFICE EXPENSES UNITED STATES & CANADA, 1987



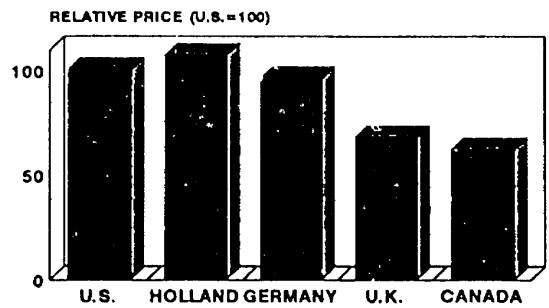
SOURCE: WOOLHANDLER/HIMMELSTEIN NEJM 1991;324:1253

CHART 8 - SHRINKING CLINICAL WORKFORCE?
CHANGE IN HOSPITAL EMPLOYMENT, 1990-1991



SOURCE: HIMMELSTEIN & WOOLHANDLER TABULATIONS FROM CPS, 1992

CHART 9 - PRESCRIPTION DRUG PRICES IN FIVE COUNTRIES

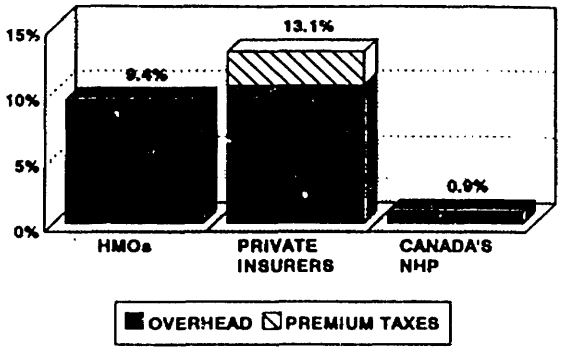


PRICE	100	107	96	68	62

SOURCE: SENATE AGING COMMITTEE/GAO

CHART 10 - HMO EFFICIENCY?

INSURANCE OVERHEAD: HMOs, PRIVATE INSURERS & CANADA'S NHP



Sources: GHAA/HIAA (excludes 2% interest credit) & Statistics Canada

CHART 11 - MANAGED CARE BUREAUCRACY?

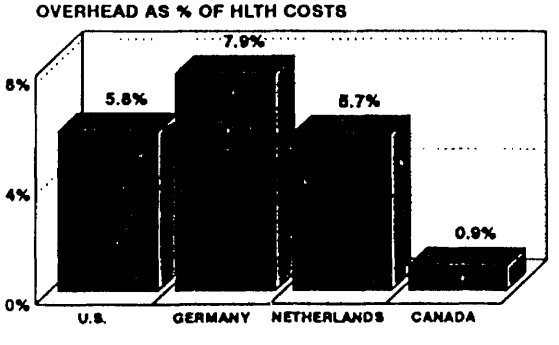
***EMPLOYEES OF PRUDENTIAL MANAGED CARE IN NJ (ENROLLMENT = 110,000)**

- 18 Nurse Reviewers
- 5 Physicians (1 Full Time, 4 Part Time)
- 8 Provider Recruiters
- 15 Sales Representatives
- 27 Service Representatives
- 100 Clerks

*EXCLUDES STAFF AT CENTRAL COMPANY OFFICE AND INSURANCE AGENCIES

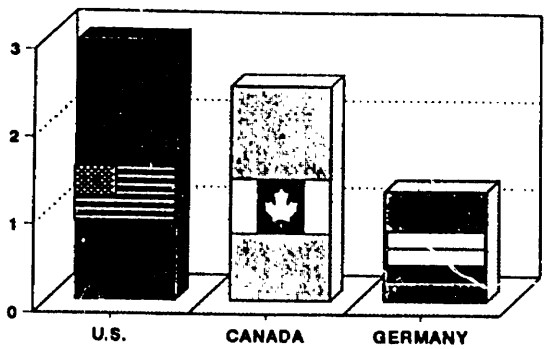
Source: NY Times 8/25/91

CHART 12 - INSURANCE OVERHEAD, 1990: U.S., GERMANY, NETHERLANDS & CANADA



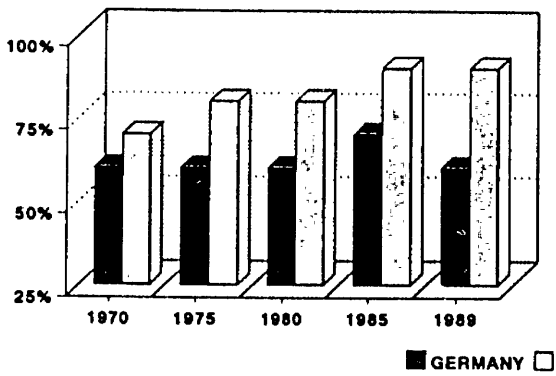
Source: OECD/Statistics Canada/NCHS

CHART 13 - NUMBER OF HOSPITAL WORKERS PER BED U.S., CANADA, GERMANY, 1987



Source: OECD, 1991

CHART 14 - HEALTH WORKERS' EARNINGS AS A PERCENT OF AVERAGE EARNINGS, GERMANY & U.S., 1970-1989



Source: OECD, 1991

PREPARED STATEMENT OF SENATOR DANIEL K. INOUYE

I wish to thank this Committee for requesting my views on universal health care coverage through single-payer health insurance programs. We are all keenly aware that the health care crisis is threatening our entire Nation, and we must all work together toward the goal of assuring that every American has access to the quality care that is available in the United States.

On June 9, I introduced S. 2817, the National Health Care Act of 1992. This comprehensive proposal was developed by the National Association of Social Workers and significantly changes the way our Nation finances and delivers health care. Like other single-payer national health care proposals, this bill would replace the patchwork of multiple public and private insurance plans with one publicly-financed health insurance plan that is administered by the federal and state governments. The plan would cover expanded comprehensive care—much more than is currently available in the typical insurance package. Every American would receive the same level of comprehensive benefits through the use of a uniform, single system that allows for equitable, cost-effective care to all.

What I believe makes this plan unique is that it goes beyond recommendations for a new payment and administrative system to issues of health policy and delivery system improvement that must surely be addressed as well if our goal is to provide appropriate, quality care for all. Accordingly, the bill includes such service delivery improvements as: a focus on prevention and health promotion services, including health education in the schools, workplace, and other community settings; the use of care coordination services to ensure efficient use of available health and mental health resources; expansion of community-based health and mental health services; and establishment of state screening and cue coordination systems for the delivery of long-term care. Additionally, the plan provides for research and demonstration grants to develop alternative models of health care delivery for special populations; to study the impact of psychosocial well-being on illness and disease; to develop approaches in encouraging healthy lifestyles; to study effective intervention models for the mentally impaired; and to examine the impact of cue coordination on treatment effectiveness and efficiency. Federal grants would also be available for innovative state-wide or local prevention, health promotion and health awareness programs.

S. 2817 treats mental health care and substance abuse treatment in the same fashion as care that would be provided for a physical ailment. No arbitrary limits on care are imposed, nor are added copayments or deductibles attached to mental health services to decrease the utilization of needed care. The plan recognizes that mental health and substance abuse service needs, like those for physical health cue, can be considered in a framework that includes preventive care, primary cue, and long-term care. Care coordination and an emphasis on the use of home and community-based treatment are viewed as the primary means of managing chronic and/or costly care in mental health and substance abuse, just as they may be used in managing chronic and long-term health cue.

I believe there are many compelling reasons why this Committee should consider the use of a single-payer national health care system as the means to extend quality care to all Americans. By definition, a single-payer system offers the greatest opportunity to save money through eliminating inefficiencies in our current systems of care and to control the growth of health care spending through the use of national and state spending caps, as well as through the use of a planned system of health care resource distribution. Because the system provides the opportunity to use resources so efficiently, comprehensive health, mental health, and long-term care coverage can be extended to everyone in the United States. The single-payer system also offers improved quality of care by providing access to those Americans who are now uninsured, underinsured, or living in areas with limited health care services to select the highest quality providers of their choice. I also believe that a single-payer system provides unparalleled opportunity for the formation of critical national health care policy and the design of innovative delivery systems that is offered through no other health care reform package.

While Hawaii does not have a single-payer health care plan, the state benefits from many of the advantages that can be achieved through a single-payer system because insurance coverage in Hawaii is primarily provided by two insurers, leading to a more efficient and simplified way of administering health insurance, as well resulting in a broader pool through which the health care risks of our population may be shared.

As you may know, Hawaii is often referred to as "The Health State." In Hawaii, we believe that good health is a right of all people and a responsibility that must be shared by all people. Our state has worked very hard to make that right a reality for all of our residents. In fact, 98 percent of our residents are now covered by our

state's health insurance programs, which include our Prepaid Health Care Act that requires employers to provide health insurance to qualified employees, Medicaid, and the State Health Insurance Program (SHIP). SHIP was created to extend coverage to those individuals who were not covered through Medicare, Medicaid, or employers' health plans and could not afford to purchase premiums on their own. In addition, our state has made a real investment in promoting public health, has made significant progress in implementing a long-term care plan for our elders and disabled, and has devoted concerted effort to the provision of preventive and primary care services to maintain a healthy population.

Hawaii has a very proud history of working for universal health care coverage for its residents. Our Prepaid Health Care Act was passed by the state legislature in 1974, and the state has worked very hard throughout the past 17 years to use existing systems and develop new systems of care to cover the various segments of our population. Hawaii's experience has been exemplary. But, quite frankly, I am not certain that the condition of our nation's health care crisis will allow other states the necessary time to replicate our system of care for their own unique populations. Additionally, I would assert that all states disparately need assistance now to control health care costs.

I believe that a single-payer national health care system offers the greatest opportunity for meeting health care consumers' needs—needs that have been too often overlooked in our national debate on health care reform. We look at health care providers' needs through a reform system; we look at the business community's needs—particularly businesses that employ a small number of employees; and we consider the role of the private health insurance system in a universal program; but, we don't often factor in the kinds of initiatives that will lead to the attainment and maintenance of good health. "Access" is a word that we use often. Unfortunately, however, we usually mean access to health insurance coverage, and not necessarily access to appropriate care.

I believe that if we were to focus on health care consumers' needs, our debate on health care reform might shift in a different direction. We might begin to focus on the creation of a health care system that:

- provides the same level of quality care to all, regardless of income, employment status, age, preexisting condition, geographic area, or current level of insurance coverage;
- is easy to understand and to use, eliminating the current confusion over copayments, deductibles, maximum benefit levels, and claims denials;
- allows consumers the freedom to select their own health care practitioners and not be restricted in choice to only those health care professionals who participate in a given provider network;
- provides security to the millions of American families who feel vulnerable because they are uninsured, underinsured, or have simply lost confidence in the ability of their insurance coverage to provide for their future health care needs; and
- is supported through progressive financing and administered efficiently so that the United States can afford it—both now and in the future.

The National Health Care Act of 1992 takes the health care consumer's needs into account and develops a system that focuses on the provision of quality, appropriate care for all.

Again, I wish to thank this Committee for requesting my views on universal coverage through public health insurance programs. A summary of the bill is attached.

SUMMARY OF THE NATIONAL HEALTH CARE ACT OF 1992 (S. 2817)

The National Health Care Act of 1992 fundamentally restructures the current health care system. This bill would offer full coverage for high quality, cost-efficient, and equitably-financed health and mental health care to all Americans. The national health plan proposes a federally-administered, single-payer system with state responsibility to ensure delivery of health services, payment to all providers, and planning in accordance with federal guidelines. The plan provides coverage of comprehensive benefits, including long-term care. Enrollees have the freedom to choose among a full range of public and private providers, including alternative delivery plans.

The national health care plan is financed primarily through a progressive federal dedicated tax on personal income and employer-paid payroll and corporate income taxes. States are expected to pay their fair share through a formula-based contribution.

While it's anticipated that the plan's costs may initially come close to the current level of health care expenditures, the unique delivery system improvements and the cost containment features built into the proposal are expected to decrease health care expenditures over time. The national health plan expands coverage to the 37 million uninsured, as well as the millions who are underinsured, and eliminates the inequities in paying for health care that characterize our current system.

COVERAGE ENROLLMENT: All persons residing in the United States are covered through the national health plan. Each person has the freedom to choose from among any of the participating public and private providers, facilities or care delivery options. Individuals will enroll in the national health plan in the state in which they reside.

Coverage through employers or other privately purchased health insurance is discontinued, although private insurance plans may provide coverage for services not covered under the national health plan.

BENEFITS

- Care coordination services.
- Primary prevention and health promotion services, including comprehensive well-child care for everyone 0–21; perinatal and infant health care; routine, age-appropriate, clinical health maintenance examinations for everyone over 21; family planning services; and school-based primary prevention programs.
- Outpatient primary care services.
- Mental health services.
- Substance abuse treatment and rehabilitation programs.
- Inpatient and outpatient hospital services, including emergency and trauma services.
- Inpatient and outpatient professional services.
- Laboratory and radiology services.
- Long-term care, including home id community-based services.
- Hospice care.
- Prescription drugs, medical supplies, and durable medical equipment.
- Dental care.
- Hearing and speech services.
- Vision care.

EXCLUSIONS: Health services excluded from coverage include cosmetic surgery, except medically necessary reconstructive surgery; and certain amenities in inpatient facilities, such as private rooms, unless medically necessary.

COST-SHARING: There are no copayments or deductibles for health care services. However, residents of nursing homes and other residential facilities are required to pay a modest room and board fee. These fees may be waived for those below the poverty line.

IMPROVED SERVICE DELIVERY PROVISIONS: The National Health Care Act provides unique and improved prevention and health promotion services; promotes comprehensive, coordinated, and continuous care that addresses the total health needs of every person through the use of primary care providers, care coordination services, and the promotion of comprehensive, integrated health delivery plans; provides access to health services to underserved populations; promotes the expansion of community-based health and mental health services; and establishes state screening and care coordination systems for the delivery of long-term care.

ADMINISTRATION: A new independent federal agency is established to administer the national health care plan. The new agency will receive policy direction from an appointed national health care board representing health experts and consumers. All responsibilities of the Health Care Financing Administration are transferred to the new agency. Medicare, Medicaid, CHAMPUS, the Federal Employee Health Benefits Program, and the Department of Veterans Affairs' health programs are folded into the national health care plan.

The agency provides the states with an annual global budget for all covered health care expenditures. The global budget for each state is based on a formula that considers size of population, age distribution, the cost of delivering care, socioeconomic factors, and a number of key health status indicators. State global budgets will include all state health block grant funds.

The states, in accordance with federal guidelines, will ensure the implementation of all state health services, determine the distribution of health care funding, develop and administer a mechanism to pay and reimburse health care providers, work with localities in undertaking health planning and coordination with appropriate social and human services, implement a quality assurance program, admin-

ister a consumer advocacy and information program, and license and regulate all health care providers and facilities.

PAYMENT TO PROVIDERS: Hospitals will receive a prospective global budget, to be developed through annual negotiations with the designated state agency. Global budgets will only be used for operating expenses. Separate funds for capital expansion and purchase of expensive, highly-specialized equipment will be subject to approval by the state. Other health care facilities will be paid either on the basis of a prospective global budget or capitation as determined by the state.

Autonomous health care practitioners and group practices will be reimbursed on the basis of fee-for-service, although group practices may choose capitation. The reimbursement rate will be based on a negotiated national fee schedule, adjusted for regional variations.

QUALITY ASSURANCE AND CONSUMER PROTECTION: The agency will establish a National Council on Quality Assurance and Consumer Protection that is responsible for determining guidelines and overseeing the quality assurance system. Quality assurance standards and certification and licensing criteria will be established for all health care providers.

Peer Review Organizations (PROs) as provided for in Title XI of the Social Security Act will be extended to cover all types of health care providers and services. The PROs will be responsible for utilize review and quality control. The composition of PROs must be multidisciplinary to reflect the types of services reviewed. Each PRO is required to have a Consumer Board to oversee the PROs, make recommendations on PRO contracts and carry out educational programs.

The federal agency will develop a national health care data base to study quality, effectiveness, utilization and cost of care with respect to all types of health and mental health services.

Federal and state consumer advocacy programs will be established to administer ombudsman programs, hotlines for complaints, consumer information and education programs. In addition, the national health plan contains a consumer bill of rights.

PLANNING: The national health plan requires state and local planning. At each level, the health planning function will include collecting and evaluating data to determine the supply of and demand for health resources, the distribution of such resources, and the health needs of the population in a given jurisdiction. Goals ad priorities will be formulated to serve as guides to the development of health policy ad programs at each level of government.

FINANCING: The national health care plan is financed primarily from a federal dedicated tax on personal income and employer-paid payroll and corporate income taxes. Additional sources of revenue include a state contribution based on a formula that ensures that each state pays its fair share, and an increase in the cigarette and alcohol tax.

All revenues are placed in a National Health Care Trust Fund. All current federal appropriation for health programs are folded into the national health program and transferred to the Trust Fund.

RESEARCH AND DEMONSTRATION GRANTS: The plan provides funds for research efforts to: develop alternative models of health delivery for special populations; study the impact of psychosocial well-being on illness and disease; develop approaches to encouraging healthy life-styles; study effective intervention models for the mentally impaired; and to examine the impact of care coordination on treatment effectiveness ad efficiency.

Funds would be available to continue to develop quality indicators for measuring treatment effectiveness in all types of health care settings, and to develop practice guidelines for physicians and other health care practitioners. Research will also be directed at reducing the number of unnecessary medical and diagnostic procedures.

Additionally, special federal grants would be available for innovative state-wide or local prevention and health promotion programs.

MEDICAL MALPRACTICE REFORMS: A special commission would be established to develop recommendations for medical malpractice reform. The goals of such reforms are to reduce the costs associated with malpractice insurance, reduce the basis for malpractice claims, target physicians and other health care providers who are incompetent, and develop mechanisms that will protect consumers who are victims of malpractice.

PREPARED STATEMENT OF SENATOR NANCY LANDON KASSEBAUM

Mr. Chairman and members of the committee, I appreciate the opportunity this morning to address the issue of health care reform and, in particular, the BasiCare Health Access and Cost Control Act, legislation I introduced earlier this year.

At the outset, let me stress that my BasiCare legislation is not a single-payer proposal, unlike the other bills to be considered at today's hearing. In fact, were it not that I will be accompanying Russian President Boris Yeltsin on his visit to Kansas tomorrow, I would be appearing at tomorrow's hearing father than today's. I thank the chairman for graciously allowing me to reschedule.

Mr. Chairman, I do not wish to belabor points already made by others regarding the seriousness of the health care crisis, nor do I wish to spend time this morning criticizing reform options with which I disagree. Rather, what I want to do is outline a compromise reform approach I believe offers a workable path out of the current impasse on health care reform.

My BasiCare legislation is comprehensive in its expansion of access to the uninsured, but it provides such expansion without resorting either to employer mandates or to single-payer coverage, both of which carry significant logistical and political liabilities.

The BasiCare plan is also firm in its restraint of rising health care costs. Importantly, however, these restraints are carefully structured to avoid government micromanagement of the health care system through rate- or fee-setting. My approach, which involves overall limits on the allowable rate of increase in premiums, may offer a bridge between those who insist on binding cost containment and those who fear over-regulation of the health care market.

Broadly speaking, Mr. Chairman, the basic intent of this legislation is to achieve much of the simplicity, stability, and cost control of a Canadian-style public system, but without giving up the private market incentives that have helped make the *quality* of American medical care the envy of the world.

Although no single plan can please everyone, I believe this approach may at least offer sufficient common ground on which to begin building a bipartisan consensus for comprehensive health care reform.

The BasiCare Health Access and Cost Control Act has been cosponsored by my colleagues Warren Rudman and Conrad Burns in the Senate; and in the House, it has been introduced by Democrats Dan Glickman and Dave McCurdy, as well as by Republican Pat Roberts. As far as I am aware, this makes BasiCare the first comprehensive health care reform proposal to have bipartisan, bicameral support.

Mr. Chairman, let me take a few moments to highlight some of the most important provisions of this legislation. With your permission, I would also ask that a more detailed discussion of the bill accompany my statement in the Record.

First, my legislation will simplify the insurance market around a single uniform BasiCare benefits package that every private insurer must offer and that every American will carry. No insurance company will be permitted to offer any non-BasiCare plans that duplicate BasiCare benefits, although they may sell supplemental policies for persons wishing additional coverage.

Second, the content of the BasiCare package will be determined by an independent commission of health care experts. As under the current military base-closing system, Congress will have the power to vote up or down on the commission's recommendations, but not to amend them. The purpose of this approach is to help assure that the sensitive task of developing the benefit package is not unduly distorted by political pressure.

Third, BasiCare will be subject to strict insurance rules protecting beneficiaries from discriminatory rating and underwriting based on health status.

Fourth, rising health care costs will be contained by placing binding annual limits on the maximum allowable rate of increase in BasiCare premiums. Such limits will create strong motivation for new efficiency in the health care delivery system, primarily by forcing insurers to manage the risk of rising costs by negotiating with providers for the establishment of efficient, integrated networks of health care delivery.

Unlike many of the other health care cost-containment proposals now under consideration, my approach does *not* seek to micromanage health care payment through government-sponsored rate- or fee-setting mechanisms. Rather, under my plan, the role of government will be simply to set firm overall cost parameters within which the private health care system must operate.

In many respects, the new integrated care networks envisioned under BasiCare resemble the so-called "accountable health partnerships" described in Dr. Alain Enthoven's "managed competition" model. An important difference, however, is that such networks under the BasiCare legislation would be subject to binding overall cost limits, whereas the Enthoven model would rely solely on market forces to keep costs down.

Fifth, health care coverage for the uninsured will be addressed by offering low-income persons direct public vouchers for the purchase of BasiCare policies. This system will replace and expand upon the current Medicaid program.

Sixth, Medicare will be gradually assimilated into BasiCare over a ten-year period, with the BasiCare commission being given authority to structure the transition.

Seventh, basic long-term care coverage will be included in the BasiCare package. I fully recognize the logistical difficulty and the potential financial cost of including long-term care in a bill like this one. Nevertheless, I believe it is imperative that we not shut long-term care out of the picture as we struggle for a solution on health care reform.

Under my bill, persons of all ages will carry BasiCare's long-term care coverage as part of their BasiCare package, thereby greatly spreading the cost of such coverage and minimizing the burden on any single individual or family.

Eighth, financing for this legislation will be obtained from three sources: (1) a limited draw of funds from the current Social Security payroll tax, not to exceed 1 percent of the tax, (2) limiting the current 100 percent tax deduction and exclusion for employer health benefit contributions to the cost of a BasiCare package, and (3) appropriation of existing Medicaid expenditures.

Finally, this legislation also includes malpractice reform, a significant expansion of community-based primary health care services, and measures to increase the number of health professionals in underserved rural areas.

Mr. Chairman, I want to conclude by stressing that whatever course we adopt on health care reform, I firmly believe it must be comprehensive. Incremental reforms, such as small group insurance market reform, would certainly improve on the status quo. However, passage of such measures in the absence of comprehensive change would, I believe, seriously compromise Congress's ability and motivation to follow up with tough action on the real problems at hand, namely cost containment and expanding access to the uninsured.

Achieving meaningful consensus on comprehensive reform will not be easy. Indeed the complexity and political sensitivity of this issue make health care reform perhaps the most daunting policy challenge now before Congress. However, Mr. Chairman, this is precisely the kind of challenge we in Congress are elected to address. As we proceed, I sincerely hope we can pull together in a bipartisan search for real answers to this very real problem.

Thank you,

Attachment.

"BASICARE" HEALTH ACCESS AND COST CONTROL ACT

KEY COMPONENTS

- Simplifies the insurance market around a single uniform benefits package (BasiCare) that every insurer must offer and that every American will carry.
- The BasiCare package will be a required offering of all private health insurance carriers and will be carried by all Americans. No insurance company will be permitted to offer any non-BasiCare plans that duplicate BasiCare benefits, although they may sell supplemental policies for persons wishing additional coverage.
- The content of the BasiCare benefits package will be determined by an independent expert commission. As under the current military base-closing system, Congress will have the power to vote up or down on the commission's recommendations, but not to amend them.
- BasiCare will be subject to strict rules protecting beneficiaries from discriminatory rating and underwriting based on health status.
- Health care costs will be controlled by placing binding annual limits on the maximum allowable rate of increase in BasiCare premiums, as well as through administrative standardization of the single BasiCare package.
- Firm limits on annual BasiCare cost growth will create strong motivation for new efficiency in the health care delivery system, primarily through expanded development of coordinated systems of care negotiated between providers and insurers.
- Health care access for the uninsured will be addressed by offering low-income persons non-transferable vouchers for the purchase of BasiCare coverage. This system will replace and expand upon the current Medicaid program.
- Medicare will also be gradually assimilated into BasiCare, and long-term care coverage will be included in the BasiCare package.
- Financing will be obtained through (a) a limited draw of funds from the current Social Security payroll tax, not to exceed 1 percent of the tax, (b) limiting the current 100 percent tax deduction and exclusion for employer health benefit

contributions to the cost of a BasiCare package, and (c) appropriation of existing Medicaid expenditures.

- The plan also includes malpractice reform, a significant expansion of low-income community health care services, and measures to increase the number of health professionals in underserved rural areas.

SUMMARY OF PROVISIONS

A. Creation of BasiCare

1. Congress will determine the broad foundations of the BasiCare package, but it will *not* be directly responsible for the details of the plan's composition. Among the foundations that Congress will require, however, will be:

a. Basic hospitalization coverage;
b. Basic outpatient services;
c. Protection against catastrophic out-of-pocket costs;
d. Coverage against extraordinary long-term care costs; and
e. Coverage for preventive care services of significant proven and recognized value in averting serious and costly medical conditions.

2. Actual development of the BasiCare package will be conducted by an eight-member independent, expert commission. Half of the members will be appointed by the president and the other half by the congressional leadership. All will serve on a full-time basis for five year terms.

3. The commission will define a benefit plan which, in its judgment, represents a minimum but fair coverage package. At its discretion, the commission may recommend limited variation in plan structure to accommodate delivery of BasiCare services in a managed care setting, provided that such variation does not compromise the basic uniformity of the national BasiCare package.

4. As under the current system for closing military bases, Congress will have the power to approve or disapprove the commission's recommendations, but only as an un-amendable package. The purpose of this mechanism is to help assure that the process of developing the benefit package is not unduly distorted by political pressure.

5. The BasiCare commission will have authority to make adjustments in the plan's content, as needed, to reflect changes in technology or in the nation's health needs. It will also have significant oversight responsibility for the health care system as a whole.

6. The commission will be charged with ongoing oversight of the *quality* of health care delivery—particularly as the system reacts to implementation of the new BasiCare structure. The commission will be required to factor findings on quality into any recommendations it makes to Congress on the content or the cost of the BasiCare package. It will also be authorized to contract with local and regional entities for the collection and dissemination of health care quality and cost data to consumers.

B. BasiCare's Role in the Insurance Market

1. All insurers in the health insurance market will be required to offer BasiCare and to accept its conditions.

2. Insurers will be barred from selling non-BasiCare policies that duplicate BasiCare benefits in any way. Supplemental policies however, will be allowed (see Section F. below). Such supplemental policies will be permitted to cover only those benefits not covered by BasiCare.

3. When the program is fully implemented, BasiCare policies will be subject to strict rating and underwriting rules aimed at assuring availability and curbing risk selection. These will include:

a. *Guaranteed Issue and Renewal:* Insurers will be limited in applying pre-existing condition restrictions on the issuance of policies and will have to guarantee acceptance of all small groups and individuals wishing to purchase coverage. Similar standards will also be applied to policy renewal.

b. *Community Rating:* Insurers will be required to set rates on the same terms to all BasiCare policyholders, both group members and individuals. Adjustments in community rating will be permitted for the age of enrollee, but will be held within limits, which will narrow over time. Community rating will apply both to group and individual policies.

c. *Portability:* Persons will no longer have to fear lack of access to coverage due to a change in employment.

4. Insurers failing to comply with the above reforms will be subject to a federal excise tax on gross premium income.

5. All persons will be required to carry a BasiCare policy, either through a group or individually. Low-income persons will receive direct public assistance for the cost of such coverage (see Section C. below).

6. Employers will not be permitted to discriminate against employees based on health status.

7. Self-insured groups will be permitted to continue self-insuring provided they can demonstrate that: (1) they are offering a BasiCare-equivalent benefit plan that adheres to all of BasiCare's conditions, (2) they can show that their costs do not differ substantially from those of insured BasiCare plans, and (3) they can demonstrate sufficient financial reserves to assure solvency and protection of patient benefits.

8. "Stop/loss" coverage sold to self-insured groups will also have to follow the same rating, issue, and renewal standards specified for BasiCare (see above).

9. BasiCare policies will be exempt from all current or future state benefit mandates. The federal preemption for BasiCare will also apply to state legislation restricting the use of managed care.

10. The health insurance tax deduction for self-employed persons will become the same as that for incorporated group plans. Currently, the group deduction is 100 percent while the self-employed receive 25 percent. Under the new program1 the deduction for both categories will be the same—100 percent for the cost of the BasiCare package (see Section E.2 below).

11. Insurers will likely find it desirable to coordinate the development of reinsurance mechanisms (risk pools) to better accommodate the rating and underwriting changes noted above. As under current law, state governments will also be permitted to create or contribute to such pools.

12. *Timing:* The above-described system for national standardization of the new BasiCare package will go into effect following congressional approval of the commission-proposed BasiCare package. This should occur three years after enactment. Preceding this will be a *phase-in period,* beginning at enactment, in which the small employer market will be subject to a variety of somewhat milder rating and underwriting reforms aimed at increasing fairness and availability of coverage in that market.

C. BasiCare Coverage for Low-Income Beneficiaries

1. The new BasiCare package will replace and supplant current Medicaid coverage. This will apply not only to Medicaid's acute care coverage, but to its long-term care coverage as well.

2. The low-income BasiCare assistance program will be administered through nontransferable federal vouchers redeemable directly to BasiCare carriers or employer plans. Such vouchers will indicate the applicable percentage of BasiCare costs a person or family is eligible to receive. Amounts corresponding to that percentage will be credited to the carrier by the BasiCare program.

3. To facilitate "one-stop shopping" for recipients, the process of application and approval for assistance will be coordinated with actual enrollment in a BasiCare plan.

4. This legislation specifies minimum income levels for which voucher assistance must be provided, but it leaves the commission discretion to propose increases in these levels, as it may deem appropriate to correspond with the new BasiCare benefit package. At a minimum, persons below 100 percent of the federal poverty line will receive full voucher assistance, and persons between 100 and 200 percent of poverty will receive assistance on a sliding scale based on income. Even persons receiving full voucher assistance will be required to pay a small per-service copayment to discourage overutilization.

5. The switch from Medicaid to BasiCare will assure that medical providers are no longer reimbursed at a lower level for treating low-income patients, as they are under the current Medicaid system.

6. To provide for a smooth transition from Medicaid to BasiCare, the Medicaid program will be retained as an administrative unit for a period of five years following standardization of BasiCare. During this transition period, present Medicaid-eligible beneficiaries will continue to receive any current Medicaid benefits that may not be included in the new BasiCare package.

7. Federal matching funds for Medicaid benefits not included in the BasiCare package will be discontinued at the end of the transition period, unless the commission has recommended—and Congress has approved—an alternate plan for disposition of such benefits.

8. Most federal and state funding currently going to Medicaid will be transferred to the BasiCare low-income assistance program (see Section E.1 below).

D. Cost-Containment Through BasiCare

The BasiCare system will put in place several strong levers for maintaining cost-control in the health care system. These include:

1. *The benefit package itself:* The BasiCare commission will be charged with limiting the scope of benefits to a reasonable minimum. Recognizing that defining a core is necessarily a subjective and difficult task, the commission will nevertheless be largely insulated from the strong provider and consumer pressure that has led, for example, to expensive state benefit mandates under the current system.

2. *Annual limits on the rate of increase in BasiCare premiums:* Insurers will be required to limit annual increases in BasiCare premiums to a federally defined maximum percentage. More specifically, the BasiCare commission each year will set a maximum allowable percentage for such premium increases. This percentage will be binding on all insurers.

As it initiates this system of premium increase limits, the BasiCare commission will also have authority to establish an average base premium for the BasiCare package from which future allowable increases will be measured. This is to guard against the possibility of insurers setting initial rates unreasonably high in anticipation of future increase limits. The commission will be permitted to apply limited geographic variation in the base rate to reflect regional differences in the cost of providing the BasiCare package.

By establishing a single, maximum allowable percentage of increase, government will be putting insurers themselves at risk for rising costs, thereby creating a strong incentive for efficiency. The government's role will be to set the overall budget parameters; finding the best way to live within these means will be up to the health care system itself—and not to government bureaucracies.

Unlike other cost-control proposals, this approach will avoid the pitfalls of government micro-management of specific insurance rates and provider fees.

It is likely that insurers will react to the new budget controls by forming organized care relationships with providers in order to share the financial risk with those providers. Under such arrangements, both insurers and providers will have a direct financial stake in keeping costs down and delivering care as efficiently as possible.

3. *Oversight of provider billing:* It is anticipated that the BasiCare premium limits described above will create a market situation in which the only way either providers or insurers can survive financially will be to enter into organized networks of care with each other, under which provider payment would likely be limited to negotiated amounts.

However, to guard against the possibility of unreasonable provider overcharges to consumers, this plan also gives the BasiCare commission authority to intervene with balance billing limitations in the event such charges do become a problem.

4. *Paperwork standardization:* All billing and claims paperwork associated with BasiCare will be standardized across carriers, and steps will be taken to provide for universal electronic billing.

E. Financing of BasiCare

The cost-controls noted above should create sizable reductions in the proportion of out-of-pocket costs now paid by most Americans for health care. Unavoidably, however, these savings will be at least partially offset by new costs associated with expanding coverage to the currently uninsured (see Section C. above).

Revenue scurces included in this bill are:

1. *A limited draw of funds from the current Social Security payroll tax, not to exceed 1 percent of the tax:* The Social Security payroll tax is now set at a level higher than is necessary to assure adequate reserves for present and future retirees. As the consumer group Families U.S.A. and others have argued, it is appropriate that at least a modest portion of these resources be devoted to the very useful purpose of overhauling our declining health care system. Just 1 percent of the current tax would equate to $56 billion a year in 1996, and even more as time goes by.

2. *Limiting the tax deduction and exclusion for employer contributions to employee benefit plans:* Under current law, 100 percent of employer payments to employee health plans are deductible to the employer and tax-exempt to the employee. This will be changed to allow such deduction and exemption only for contributions associated with BasiCare coverage. Additional payments for supplemental coverage will be taxable.

3. *"Capturing" existing Medicaid funding:* As Medicaid is replaced by BasiCare, its current funding will be redirected to the BasiCare program. At the federal level, this will be accomplished by posting existing Medicaid expenditures to BasiCare and indexing the amount upward each year according to inflation. Similarly, the states

will be required to contribute to BasiCare an amount proportionate to their current Medicaid match. This, too, will be indexed upward with inflation.

F. Role of Supplemental Insurance

1. As mentioned above, BasiCare will act as the primary health insurance source for all citizens, but persons or groups will be able to purchase supplemental policies for services not covered by BasiCare.

Leaving room in the market for a supplemental insurance market will serve a dual purpose. First, it will allow persons or groups the freedom of choice to tailor coverage to their own particular needs. Second, a private supplemental market will provide greater incentives for the development of innovative treatments than might be the case were BasiCare the only available option.

2. To guard against potential abuses of the supplemental market, the BasiCare commission is given strong oversight authority to monitor behavior in the new supplemental market and to intervene with explicit consumer protection or cost controls should market abuses or unreasonable cost growth develop.

G. Assimilation of Medicare

1. The commission will be directed to develop a comprehensive proposal for integration of the current Medicare program into the BasiCare system. Such proposal, in legislative form, will be required no later than the fifth year after the new BasiCare system has been implemented. This proposal will be considered in Congress under the same terms of limited debate as the initial BasiCare package (see Section A, below).

2. CHAMPUS and FEHBP will also be assimilated into the BasiCare system.

H. Expansion of Community Health Services

—New federal funding will be allocated for Community Health Centers (CHCs) *and* for other state and local public health clinics. Such centers have a good record of providing inexpensive, cost-effective treatment to indigent and low-income persons. Authorization is $600 million annually in new funding for these programs.

I. Malpractice Reform

1. Provides federal preemption for comprehensive medical liability reforms. These include: mandatory periodic payment of future awards, caps on noneconomic and punitive damage awards, mandatory offsets of awards for collateral sources of recovery, and court-determined reasonable attorneys' fees.

2. Establishes a program of grants to states to encourage implementation of alternative dispute resolution (ADR) systems, such as fault-based, no-fault, or binding arbitration. Authorization is $250 million annually for three years.

3. Establishes special demonstration projects to test implementation of no-fault systems of compensation. Authorization is $20 million annually for three years.

J. Joint use of Equipment and Services

1. Clarifies antitrust law regarding joint service ventures to facilitate collaboration among hospitals for the purpose of sharing expensive high technology equipment or services.

2. Specifically, this provision amends the National Cooperative Research Act to allow joint service ventures by two or more hospitals for the delivery of costly services. It will apply the rule-of-reason standard to joint service ventures that are challenged, allowing the court to consider the competitive benefits of the venture.

K. Expanding the Supply of Health Professionals in Rural Areas

1. Significantly expands funding for the National Health Service Corps, a program to place doctors and other health professionals in underserved areas in exchange for scholarship or loan repayment assistance. Authorization is $120 million for each of the next five years.

2. Physicians will be allowed a tax credit equal to $1,000 a month for practice in a rural health professions shortage area. Nurse practitioners and physician assistants will be eligible for a similar credit equal to $500 per month.

3. Provides additional tax incentives for rural practice, including deductibility of National Health Service Corps loan repayments and deductibility for the cost of basic medical equipment.

PREPARED STATEMENT OF PETER A. MAGOWAN

Mr. Chairman and members of the Committee, thank you for this opportunity to discuss health care reform with you. I am the chairman, president, and chief executive officer of Safeway Inc. I am here on behalf of the National Leadership Coalition for Health Care Reform. With me is Dr. Henry E. Simmons, president of the National Leadership Coalition, and Ronald F. Zachary, senior vice president-human resources at Safeway.

By way of background: Safeway is the nation's third largest supermarket chain. We operate 875 stores in 17 states and the District of Columbia, together with an extensive network of distribution and manufacturing facilities. We are a highly labor-intensive company, with approximately 110,000 employees -- 78,000 in the United States.

I am here today because I am very concerned -- about the health of our employees and about the financial health of our company and industry. Last year, Safeway's cost for providing health coverage to our U.S. employees and their dependents was almost $225 million. That was more than four times our net profit for the year. Especially with health care costs spiraling up so rapidly, these numbers are alarming -- and they are unsustainable.

That is why I have been actively involved in the National Leadership Coalition for Health Care Reform. The Coalition is the largest and broadest private-sector alliance in support of comprehensive health care reform. Our membership includes many large corporations, such as Safeway, Chrysler, Xerox, Time-Warner, Southern California Edison, Anheuser Busch, Georgia-Pacific, and Dayton-Hudson -- and a growing number of small businesses as well. It includes labor organizations, such as the Service Employees International Union, the United Food and Commercial Workers International Union, the American Federation of Teachers, and the National Education Association. It includes consumer and other not-for-profit groups, such as the American Association of Retired Persons, the Families USA Foundation, and the Christian Children's Fund. And it includes organizations of health care providers, such as the American Nurses' Association, the Association of Minority Health Professional Schools, and the Texas Heart Institute. I have attached to my testimony current lists of our organizational and individual supporters (Exhibits A and B).

The National Leadership Coalition is a non-partisan alliance. Our honorary co-chairmen are a Democrat and a Republican: former Presidents Jimmy Carter and Gerald Ford. And our co-chairmen are a Democrat and a Republican: Paul G. Rogers, former chairman of the House Subcommittee on Health and the Environment, and Robert D. Ray former governor of Iowa.

The organizations that I mentioned, and many others, have come together in the belief that we face a genuine crisis in American health care -- a crisis that is so grave, and so urgent, that comprehensive reform is needed as soon as possible. After 18 months of study and deliberation, the Coalition reached consensus on a broad package of reforms. We released our proposal in November of last year.

Misconceptions about "Play-or-Pay"

At the outset, let me make some brief comments about the framing of the health care debate. Our plan includes, among its many other provisions, a mechanism that has come to be called "play-or-pay" -- a requirement that employers either purchase health insurance for their employees and their families directly or enroll their employees and their families in insurance under public sponsorship and pay a tax toward the cost. And, I should mention, under our proposal, employees whose firms chose the pay option would also contribute, through a payroll tax, to the financing of insurance.

That phrase, "play-or-pay," concerns us for two reasons. The first is it sounds punitive -- as though any plan that included such a provision has to be, ipso facto, bad for business. Safeway doesn't believe that, and neither do any of the other companies, large and small, that support the Coalition's plan. To the contrary, we believe that our plan -- which goes way beyond that provision to include tough cost controls, initiatives to improve the quality of care, the development of organized delivery systems, administrative simplification, and insurance reform -- would be good for business and good for the economy.

And that leads me to our second concern about the phrase "play-or-pay," which is that it is often used to distort what we and others are proposing. I recently wrote a Wall Street Journal op-ed piece, a copy of which is attached (Exhibit C), responding to an analyst who had criticized our proposal as though it had nothing in it other than a play-or-pay mechanism. That critic was not alone in taking this tack of oversimplifying our proposal -- and then attacking the oversimplification. So as we debate health care reform, let's try to hold fast to a distinction between play-or-pay provisions and the plans in which they are found. A play-or-pay requirement wouldn't make sense all by itself, but it works well in the context of our broader proposal.

I want to address two sets of issues today:

o first, how the Coalition developed its proposal -- and, in particular, why we favor what the Committee has termed employment-based health care reform.

o second, what, specifically, the Coalition's plan for reform includes; here I want to stress the breadth of our proposal and how its elements work together.

The Three Crises

When the Coalition began its work in 1990, we did not move directly to a discussion of various options for reform. Instead, we began by considering what problems needed to be addressed, and then we developed principles to guide our thinking about alternatives. It was only after we had reached agreement on the nature of the problems and on the requisites of reform that we sorted out the options and reached consensus on a proposal. We found this process of thinking through the issues together, step by step, essential to building the shared understandings that made agreement, among so many diverse interests, possible.

Our view of the health care crisis is that it has three components -- and that they are interconnected and mutually reinforcing.

The first is a crisis of cost. It is clear that health care is a crucial issue of economic, as well as social, policy -- that our efforts to encourage sustained economic growth have to include effective constraints on health care costs. Health care spending in America is spiraling out of control -- $738 billion last year, an anticipated $817 billion this year, and, unless we act soon to slow the growth in health care costs, more than one

and a half trillion dollars a year by 1997. These numbers are staggering, and they may seem literally incredible -- until we consider that our current level of spending would have seemed equally incredible not so long ago.

Last year, corporate health care expenditures were the equivalent of 45 percent of net corporate profits -- and just the one-year jump in health care costs amounted to 36 percent of the total growth in our gross national product. Increases in health care spending are draining off capital that could otherwise be used to finance growth and the creation of jobs. They are making it more difficult for American firms to compete in world markets against companies from countries with much lower health care costs -- which is to say, all countries. By way of example, we spend twice as much on health care per person as Germany and 2.3 times as much as Japan.

Increases in health care costs are also enormously complicating our efforts to tame the federal deficit, as the recent Senate debate about entitlement caps made clear. They are impinging on our efforts to find resources to respond to other pressing domestic needs, such as initiatives that would help our cities and improve the education of our children. And, not least, they are pricing millions of Americans out of the health care market.

And that leads to the second crisis: the crisis of access. On any given day, more than 35 million of our fellow citizens -- one-third of them children -- have no health coverage, and millions more are under-insured. They live in constant physical and financial jeopardy. And even these number understate the crisis of access. In the course of a year, nearly 50 million Americans will be without health coverage a portion of the time -- more than one in every five Americans. What's more, in a difficult economy, many who have coverage now worry about losing it. That's why the polls tell us that guaranteed coverage is what Americans most want from health care reform, by margins of more than four to one.

The third crisis is the least often recognized: the crisis of quality. Most of us assume that American health care is first-rate. But the truth is that only some of it is. There is, to begin with, a stunning amount of variation in the frequency with which particular procedures or courses of care are used. A few examples from recent studies make the point: Tonsillectomies were found to be eleven times more common, on a per-capita basis, in one Vermont town than in a neighboring community; the use of lumpectomies for the treatment of breast cancer -- instead of mastectomies, in which a woman's entire breast is removed -- was six times more common in Massachusetts than in Kentucky; and coronary bypass operations were more than twice as common, and carotid endarterectomies less than half as common, in New Haven than in Boston. The central explanation for these differences seems to be this: We just do not do enough systematic assessments of the effects of alternative technologies and treatments -- and to the extent that assessments are done, the results are not made sufficiently accessible to health care professionals. As a result, these professionals do not know as much as they would like to know -- or as much as we would like them to know -- about what works, when.

What about the skill with which health care is delivered? It is difficult to generalize about levels and consistency of skill, but an analysis of hospitals in New York state, conducted by the Harvard Medical Practice Study Group, is a chilling indicator: If the patterns found in New York are typical of what transpires nation-wide, Americans may experience as many as 1.2 million unexpected adverse effects from hospitalization each year -- and as many as 180,000 may die as a consequence. Half of those deaths, according to the investigators, would be due to negligence. And

two recent studies found that in-hospital death rates for patients undergoing heart bypass operations varied by as much as a factor of four from hospital to hospital (3 percent to 12 percent) -- and by as much as a factor of five from surgeon to surgeon (2 percent to 10 percent). For all that we spend on health care, many Americans suffer -- and, apparently, many die -- because of care that is not good enough.

Our crisis of quality is also manifested in an extraordinary level of inefficiency: According to the former editor-in-chief of the New England Journal of Medicine, at least 20 to 30 percent of what is done by well-meaning physicians in good hospitals is either inappropriate, ineffective, or unnecessary. Two Secretaries of Health and Human Services have estimated that waste in our health care system amounts to between $100 billion and $150 billion a year.

Guiding Principles

What became clear to us as we wrestled with these three dimensions of the health care crisis is that for reform to be effective, it has to address all of them at once -- and not just because we need progress on all three fronts. The American health care system is exceedingly interdependent, and we run the risk, if we settle for partial reform, of just changing the mix of problems. For example, a major expansion of access without concurrent improvements in quality and effective cost control would result in more people receiving lower-quality care at a much higher overall cost. Similarly, tough cost control by itself, unaccompanied by other measures, would reduce both access and quality. And an effort to bolster quality, without attending to the other dimensions of the health care crisis, would drive up costs and further constrain access.

We decided, then, that we had to develop a package of reforms that would work together to guarantee health coverage to all Americans, control costs effectively, and improve the quality of care. But more than that, we needed to make sure that the reforms we developed worked across the whole health care system. One lesson from the federal government's experience with measures to control its own health care spending is that reform that focuses on one piece of the system shifts costs to another; it is not mere coincidence that the advent of fee schedules to constrain federal health care reimbursement has been accompanied by outsized jumps in insurance premiums for the private sector. Unless reform is system-wide, gains in some sectors or for some consumers of health care will be offset by losses elsewhere.

The third principle that guided our thinking about reform, and that we would commend to the members of the Committee, is this: Reform ought to build on and around the strengths of the present system. Health care reform is a delicate balancing act. We should make sure that in trying to create a better health care system for the future, we do not in the process undermine our capacity to meet the health care needs of our current population. That is why the Coalition, in considering a range of possible plans for reform, focused on alternatives that did not involve the potential for major disruption in the delivery of health care. We have proposed a public-private partnership that would build on and around current institutional arrangements -- rather than trying to replace them all at once with one model or another of health care delivery.

We constructed our plan for reform around current financial arrangements as well, rather than propose a wholly new financial structure, such as a national health insurance system, that could require large tax increases and economic dislocations. Right now, 70 percent of the Americans who have health coverage receive it through their employers -- that is the central characteristic of the American way of financing health insurance. We think it

makes good sense, as a matter of practicality and prudence, to incorporate and augment, rather than jettison, the purchase of insurance by employers -- to construct a system for universal coverage that pivots around this base.

The fourth principle that the Coalition followed is simply this: We cannot afford to gamble with the health care system. There are reform proposals circulating now that center on devices -- whether financial or structural -- that have not been tested yet, or much, in the real world. I have attached to my testimony two op-ed pieces -- one by former Iowa governor Robert D. Ray, who co-chairs the Coalition, and the other by Dr. Simmons -- that discuss such proposals (Exhibits D and E). The Coalition believes, strongly, that we ought to err on the side of caution. There is just too much at stake in the health care system -- for the health of Americans and for the vigor of our economy -- to take unnecessary risks. In this respect, the Coalition's plan may fairly be described as conservative. It draws on ideas that have already been tested and proven to work in the United States -- in individual states, at the federal level, and in the private sector -- such as expenditure targets, fee schedules, and the assurance of universal coverage through an employer-based system. It's an American health care plan -- and a sensible one.

The Coalition's Proposal

The Coalition's plan grew out of, and satisfies, the principles I have described: It addresses all three dimensions of the health care crisis; it is system-wide; it builds on and around the strengths of the present system; it is prudent. And it meets another standard for reform as well: It has commanded support from an extraordinary range of interests.

Ours is the most comprehensive plan for health care reform proposed to date. It has eight main elements:

1. Universal Coverage and Individual Responsibility

Every American would be guaranteed access to a defined, comprehensive package of health benefits. The particulars of that package are described in Exhibit F. Those who are not otherwise insured would be able to receive their insurance coverage -- and the same package of benefits -- under public sponsorship, through an initiative that we call Pro-Health (and that would incorporate the acute-care portion of Medicaid). Our proposal would empower and require every American to obtain coverage, at least to the extent of the standard benefit package -- from an employer, by individual purchase, or through Pro-Health.

Employers would have two options -- either to provide coverage to their employees and their families or to enroll them in Pro-Health and pay a payroll tax to help finance the cost. In keeping with our emphasis on individual responsibility, we would also require employees whose firms chose the latter option to contribute, through a separate payroll levy, to the financing of insurance. Most employers purchase insurance for their workers now, but their premiums are leaping up, often more than 20 percent a year, under the current, uncontrolled system. Our plan, with its tough cost controls, would save these firms money and allow them to plan for what many now see as an essentially unpredictable expense. Small businesses that do not provide coverage now, and start-up firms, would be phased into compliance with the plan over three years. We anticipate that for many firms with low average wages, the option of enrolling employees in Pro-Health would be attractive. The payroll tax rate associated with this alternative would be set at a level calculated (and adjusted as needed) to produce and maintain at least a three-to-one ratio between those insured directly, by themselves or their employers, and those who are insured through Pro-Health.

2. Cost Control

The Coalition's plan includes the toughest, most comprehensive set of cost control measures yet proposed. At its center are three tools: first, annual system-wide expenditure targets that would cut the rate of growth in the nation's health care bill two percentage points a year until it matches the rate of growth in the GNP; second, payment rates for providers, set at levels calculated to keep overall spending at or below the annual expenditure targets; and third, annual targets and rate factors to constrain capital spending.

Other pieces of the Coalition's proposal would work in conjunction with these three measures: increased use of preventive care, which would decrease the need for more expensive actute care later; increased efficiency in care as a result of our quality initiative and the development of organized delivery systems; reductions in the unnecessary use of technologies and procedures, due to increased assessments research and the promulgation of national practice guidelines; a decline in defensive medicine as a result of the guidelines and malpractice reform; and administrative simplification.

In the report we issued last November, Excellent Health Care for All Americans at a Reasonable Cost, we estimated that the Coalition's plan would reduce overall health care spending, relative to what it would be in an unreformed system, by $40 billion in the second year of implementation -- and that by the end of this decade, savings would exceed $600 billion a year.

3. Initiatives to Improve the Quality of Care

The Coalition's plan calls for the development, under the auspices of a new public-private National Board on Health Care Quality, of national practice guidelines that codify the best available information about the effects of alternative technologies and procedures. These guidelines would be used in decisions regarding payments to providers and as standards in malpractice cases. The Board would disseminate the guidelines to those who deliver care and make them readily available to others -- employers, insurance companies, and consumers -- who wish to be informed about them.

The Board would fund new research, in order to generate more and better data about the effects of technologies and procedures. In addition, it would work to upgrade the skill and efficiency with which health care is provided -- for example, by helping health care organizations institute continuous quality improvement programs.

4. Organized Delivery Systems

The Coalition recommends a major effort to encourage the emergence of organized delivery systems (ODSs), one-stop health care providers that would be responsible for a wide range of services, including inpatient, outpatient, and long-term care. ODSs would compete with each other and with the fee-for-service sector on their ability to manage the quality and quantity of care they provide -- and, as a consequence, would have strong incentives to develop and enforce practice protocols, institute programs of continuous quality improvement, and avoid waste. But we recognize that the full flowering of organized delivery systems would not be the product of a single season, or even of a single decade. As with other good ideas for delivery system reform, this one has to be preceded, and encouraged, by tough cost control, and it has to be nurtured in the context of a comprehensive package that encourages, and creates tools for, increased efficiency and quality.

5. Insurance Reform

Current insurance practices make it difficult for many small businesses to obtain health insurance for their employees at reasonable rates. To encourage more small businesses to provide health coverage for their employees directly, each insurer would be required to do three things: first, offer small groups the new standard benefit package (all state mandates regarding minimum benefits would be eliminated) -- and accept all groups that seek health insurance in the geographic area served by the insurer; second, set premiums on the same terms, with a return to community rating, for all groups in an area; and third, renew all policies with premiums adjusted on an area-wide, not firm-by-firm, basis. The plan's system-wide cost controls would help to make sure that the savings that these measures would confer on some businesses would not be offset, through the magic of cost-shifting, by premium hikes for other firms.

6. Malpractice Reform

National practice guidelines would go a long way toward reducing the amount of malpractice (and the incidence of defensive medicine). Moreover, because they would serve as evidence in malpractice cases of what is considered best practice, they would help to protect health care providers from frivolous lawsuits. To change the law and policy governing malpractice, the Coalition also proposes holding ODSs liable in malpractice cases involving care given under their auspices, testing (and then adopting) alternatives to malpractice litigation, establishing a new recredentialing system -- focusing on patterns of practice -- for health care professionals, and instituting a variety of tort law reforms.

7. Administrative Simplification

The administrative costs of the current health care system -- estimated to account for as much as a quarter of overall spending -- are unproductive uses of our scarce resources. The Coalition's plan -- in particular, the establishment of a standardized benefits package, universal coverage, uniform rates and claims forms, and electronic billing -- would result in a health care system that is less costly, and less cumbersome and frustrating for health care professionals and patients alike.

8. Management and Oversight

The Coalition's plan involves the creation of a public-private partnership for the improvement of the American health care system. An independent National Health Review Board -- with members representing health care providers, payers, and consumers, as well as government -- would be responsible for overseeing that effort and for setting expenditure targets and payment rates. Analogous State Health Review Boards would certify ODSs, manage the operations of Pro-Health in the states, and administer payment methods.

We are heartened that so many organizations, from so many sectors affected by and participating in the health care system, have either joined the Coalition directly or issued proposals of their own that are similar in many respects to our own. There is good reason to hope that with leadership from you, the members of this Committee, and from your colleagues, a consensus can be forged, across the conventional alignments of economic interest and partisan identification, in support of comprehensive reform. We want to work with you to that end.

I will close with a message of urgency. Every year we delay effective cost control, health care spending in this country jumps 12 to 13 percent. Every year we delay universal coverage, more Americans join the tens of millions already living on the

edge, without health insurance. And every year we delay initiatives to improve quality, more of us risk mortal harm from substandard care.

We know that this unrelenting accumulation of cost and fear and danger cannot be allowed to continue indefinitely. And we know that it doesn't have to. Let's work together -- the private sector and the public sector, across divisions of partisanship and ideology. Now, before the crisis gets even worse.

EXHIBIT A

Acme Steel Company
American Association of Retired Persons
American Federation of Teachers, AFL-CIO
American Iron & Steel Institute
American Nurses' Association, Inc.
American Psychological Association
American Physical Therapy Association
Anheuser Busch Companies
ARMCO Steel Co., L. P.
Association of Minority Health Professional Schools
Bethlehem Steel Corporation
Children's Defense Fund
Christian Children's Fund
Chrysler Corporation
Cold Finished Steel Bar Institute
Control Data Corporation
Cox Enterprises Inc.
Dayton Hudson Corporation
Del Monte Foods
Families USA Foundation
Georgia Pacific Corporation
Giant Food Inc.
The Great Atlantic & Pacific Tea Company, Inc.
Gross Electric Inc.
The Heights Group
Hunt Wesson Inc.
Inland Steel Company
International Brotherhood of Electrical Workers, AFL-CIO
International Multifoods
James River Corporation
Johnstown Corporation
Keebler Company
Keller Glass Company
LTV Steel Company
Lincoln Telephone & Telegraph Co.
Lockheed Corporation
Meredith Corporation
National Education Association
National Steel Corporation
Northern Telecom Inc.
Norwest Corporation
Olympia West Plaza, Inc.
Pacific Gas & Electric
Preferred Benefits
The Quaker Oats Company
Ralphs Grocery Company
Safeway Inc.
Service Employees International Union, AFL-CIO
Southern California Edison Company
Strategic Marketing Information, Inc.
Texas Heart Institute
Time Warner Inc.
United Food and Commercial Workers International Union, AFL-CIO
United Paperworkers International Union, AFL-CIO
United Steelworkers of America, AFL-CIO
U. S. Bancorp
The Vons Companies, Inc.
Westinghouse Electric Corporation
Wheeling-Pittsburgh Steel Corp.
Xerox Corporation

EXHIBIT B

Individual Supporters of the Proposal of

The National Leadership Coalition for Health Care Reform

Former President Jimmy Carter

Former President Gerald Ford

Governor Booth Gardner
Governor of Washington

The Honorable Frank Carlucci

The Honorable Barbara Jordan, J.D.
L.B.J. School of Public Affairs

Stuart Altman, Ph.D.
Dean, Florence Heller School
Brandeis University

Roger J. Bulger, M.D.
President & CEO
Association of Academic Health Centers

Robert A. Heyssel, M.D.
President & CEO
The Johns Hopkins Health System and Johns Hopkins Hospital

Charles C. Edwards, M.D.
President
Scripps Clinic & Research Foundation

Harvey Fineberg, M.D., Ph.D.
Dean
Harvard School of Public Health

Donald C. Harrison, M.D.
Senior Vice President and Provost for Health Affairs
University of Cincinnati Medical Center

Thomas N. James, M.D.
President
The University of Texas Medical Branch at Galveston

Ronald P. Kaufman, M.D.
Vice President for Health Sciences
University of South Florida

Peter O. Kohler, M.D.
President
Oregon Health Sciences University

M. David Low, M.D., Ph.D.
President
The University of Texas Health Science Center at Houston

Donald A. Brennan
President & CEO
Sisters of Providence, Seattle

Gilbert S. Omenn, M.D., Ph.D.
Dean, School of Public Health
University of Washington

James A. Pittman, Jr., M.D.
Dean, School of Medicine
University of Alabama Academic Health Center

James Cuthbertson
President & CEO
Texas Heart Institute

Neal Vanselow, M.D.
Chancellor, Tulane University Medical Center

Edmund D. Pellegrino, M.D.
Director, Center for the Advanced Study of Ethics
Georgetown University

Ralph Snyderman, M.D.
Chancellor for Health Affairs
Duke University School of Medicine

A Great Prognosis for 'Play or Pay'

Counterpoint

By Peter Magowan

The Wall Street Journal's editorials haven't explicitly criticized "play or pay," the health care reform that would require companies to give employees insurance or pay a payroll tax. But signed articles on the editorial page have. Stuart Butler's recent essay on the topic charged that this mechanism is "bound to lead to surging costs." Let me assure the readers of the Journal: He is wrong.

My company, Safeway, does support a plan that includes a "play or pay" requirement, as do other members of the National Leadership Coalition for Health Care Reform. But our program is not, as Mr. Butler suggests, merely the unadorned requirement that employers either provide health coverage or pay a payroll tax. Competing as we do in an industry where net earnings average about 1%, Safeway would never endorse a proposal for health-care reform that did not include tough cost controls.

The Coalition's plan does. It calls for setting an annual target for national overall health-care spending—and for fee schedules calculated to assure that spending does not exceed the target. The expenditure targets would cut the growth in health-care spending by two percentage points each year until it matches the rate of growth in the overall economy. We project that by the year 2000, the Coalition's cost control mechanisms would generate annual savings—compared with health-care spending in an unreformed system—of more than $800 billion a year.

No proposal for health-care reform has a stronger provision for cost control. By totally ignoring this part of the Coalition's plan, Mr. Butler manages to deprecate not only the proposal itself, but also, by implication, those who lead the organizations—unions, consumer groups and associations of health-care providers, as well as companies that support it. Incidentally, cost control wouldn't lead to rationing, as the Journal's recent editorial, "Health-Care Primer" warned. We now spend 13% of the nation's economy on health care—about twice the proportion spent by nations in which rationing has surfaced. By working excess capacity out of the system, by reducing the incidence of unnecessary procedures, through the use of practice guidelines and an efficiency-driven organized delivery system, and by simplifying administration—all of which our plan would do—we can cut costs without any need for rationing.

The corporate community has a huge stake in making sure that health-care spending is brought under control—nationally. According to a study by the consulting firm A. Foster Higgins & Co., the per-employee cost of our health plans has jumped in just four years—between 1987 and 1991—from $1,985 to $3,685. Corporate health-care spending is now the equivalent of 65% of net corporate profits. And we know that these outsized increases in health-care costs—on a base that's already more than twice as high per person as what the Germans and the Japanese pay for health care—put us at a disadvantage relative to our overseas competitors. As President Bush recently said in another context, this will not stand.

Mr. Butler's secondary argument also misrepresents the plan that we, and the other companies he cited, support. He contends that under the plan companies would be likely to discriminate in hiring decisions against job candidates likely to incur high medical costs. But in order to make that argument he overlooks another element of the Coalition's proposal: insurance reforms. These reforms—including a requirement that insurance companies set premiums on the same terms, with a return to community ratings, for all firms in an area—would cut the incentive that some firms may have under the status quo to engage in that sort of discrimination. Moreover, to bolster his argument, he cites a provision on discrimination in a Senate bill that is nowhere to be found in the proposal that we and our colleagues have advanced.

Cost is one of the three interlocking pieces of the health-care crisis. The other two are access and quality—and the Coalition's plan addresses them as well.

The plan would cut growth in health-care spending two percentage points a year.

More than 34 million Americans have no health coverage now. They live in constant jeopardy. And the longer we delay assuring universal access to health care, the more Americans will find themselves without health insurance, as companies continue to lay off workers or, as premiums escalate, eliminate coverage.

The Coalition's plan would guarantee comprehensive health coverage to all Americans. Most employees and their families would continue to receive health insurance through their employers, as they do now. Everybody else would be enrolled in insurance under a public sponsorship—an initiative we call Pro-Health.

Quality is the sleeper issue in health-care reform. Most of us assume that American health care is first-rate. The truth is that only some of it is. The quality of care varies widely—from locality to locality, from hospital to hospital, and from doctor to doctor. For all that we spend on health care, many Americans suffer needlessly because of care that is not good enough. Twenty-two countries have lower rates of infant mortality than the U.S., and 15 have higher average life expectancies. A study by the RAND Corporation found rates of inappropriate care ranging from 14% (for coronary artery bypasses) to 32% (for carotid endarterectomies). And if the patterns found in New York state by the Harvard Medical Practice Study Group are typical of what transpires nationwide, Americans may experience as many as 1.2 million unexpected adverse effects from hospitalization each year—and as many as 180,000 may die as a consequence. Half of those deaths, according to the investigators, would be due to negligence.

The Coalition's proposal would launch a major effort to improve the quality of American health care, including the development of national practice standards that incorporate the best information we have now about the effects of alternative technologies and treatments—and a stepped-up program of outcomes research to build our knowledge about what works best under what circumstances.

The one piece of our proposal that Mr. Butler chose to focus on takes up less than three pages of our 32-page report, Excellent Health Care for All Americans at a Reasonable Cost. It cannot be viewed in isolation, because that is not how it would operate.

Is our plan, as the headline to Mr. Butler's piece suggests, "bound to be a loser"? It's hard for me to see why the American public wouldn't get behind a program that can save us $600 billion a year by the end of the decade, provide coverage to the 34 million Americans who now live life with no health insurance, and improve the quality of the care we receive.

Mr. Magowan is chairman, president and CEO of Safeway Inc.

THE WASHINGTON POST

SUNDAY, JANUARY 26, 1992

EXHIBIT D

Health Tax Credits? A Sickly Idea

Here's a Plan That Won't Do Anything to Make the System Work

By Robert D. Ray

IF MILLIONS of Americans don't have health insurance because they can't afford it, why not give them a tax credit to pay for it? As a free-market Republican, I understand the appeal of a strategy that works simply and unintrusively through the market. And I'm not surprised that members of Congress and—to judge from press reports—the Bush administration have found the idea of a health tax credit intriguing. I found it intriguing as well, but I have come to recognize that our health system has developed ailments so extensive and acute that a tax credit would have far less impact than its proponents hope.

To see why there is a mismatch between the ills of the health care system and the tax-credit prescription, consider briefly what those ills are and how they reinforce each other.

■ *The coverage crisis.* Too many Americans—34 million, more than one-third of them children—have no health coverage. And their number is growing as companies lay off workers or, as insurance premiums escalate, eliminate coverage.

■ *The cost crisis.* Last year, America spent 13 percent of its GNP on health care—$738 billion. And our health care costs are climbing at double-digit annual rates. This year, 36 percent of our economic growth will be eaten up by increases in health care spending. What's more, high health care costs put U.S. firms at a disadvantage relative to overseas competitors—we spend, for example, twice as much on health care per person as Germany and 2.3 times as much as Japan.

■ *The quality crisis.* Most of us assume that U.S. health care is first-rate. In fact, the quality of care varies widely. For example, two recent studies found that death rates for patients undergoing heart bypass operations differed by as much as a factor of four from hospital to hospital and by as much as a factor of five from surgeon to surgeon.

Now consider how a tax credit would measure up against these needs. A tax credit would not slow health spending; in fact, it would increase it by pumping more money into the system. To control costs, and stop cost-shifting to business, we need to set a spending target and develop a fair fee schedule to keep total system costs at or below that level. That's the process used for hospital reimbursement under Medicare—and it works.

Nor would a tax credit improve quality. For that we need to do more and better research on alternative treatments and technologies—and to develop practice guidelines, so that caregivers have the best information available on how to help patients.

Which leaves us with the question of health coverage. All the recent public opinion polls I've seen show the overwhelming majority of Americans—across political parties—believe this country should assure universal access to health care. How well would a tax credit serve this purpose?

To answer that question, let's look at the issues involved in designing what is called a refundable tax credit. Here's how it would work: For those who buy health insurance directly, instead of receiving it as an employee benefit or under a government program, the cost—up to a specified limit—could be offset against federal income tax liability. A taxpayer whose tax liability was less than the credit would receive a government check for the difference.

The first dilemma a tax credit plan faces has to do with the size of the credit. If the credit is large relative to the cost of health insurance, it will induce more people without coverage to obtain it—but also cost the Treasury more. A credit of, for example, $1,000 per person would cost $34 billion if every one of the uninsured—and nobody else—were to take advantage of it. But even a credit this large would not guarantee access to health coverage.

Millions of low-income Americans would not be in a position to pay the cost of health insurance up-front—a fact of their lives that would not be altered by the availability of a refundable tax credit the following year. And even if we could somehow get past that problem, many would still find the residual cost of insurance too high; it is not unusual for individual coverage to run more than $1,800 a year.

Moreover, reliance on a tax credit to assure coverage assumes that cost is the only impediment. It is not. Some Americans have trouble obtaining coverage because of preexisting medical conditions, high-risk employment or other factors that make my colleagues in the insurance industry leery—barriers that would remain absent changes in insurance rules.

A smaller tax credit would be cheaper but fall still shorter of assuring universal coverage. Recent academic studies indicate that refundable tax credits of about $500 to $600 for an individual and $1,200 to $1,400 for a family might reduce the number of uninsured Americans from 34 million to 29 million—only a modest step.

The second dilemma for a tax credit plan has to do with targeting. If a tax credit is available to all taxpayers (or at least to those with incomes below a ceiling), much of the revenue lost because of the credit will go to people who already pay for part or all of their own insurance. On the other hand, if a credit is limited to those who do not have health coverage, some employers will be induced to terminate their employees' coverage and keep the savings.

This would obviously drive up the cost of the tax credit. What's more, it could have the perverse effect of actually reducing insurance coverage if the credit were too modest to allow many people to buy adequate insurance. Any plan that offers a government-subsidized alternative to direct employer insurance creates some incentive for companies to opt out of providing coverage, but with a tax credit, companies could save *all* their current costs.

It has recently been suggested that an employer-based strategy—such as the one included in the reforms proposed by the National Leadership Coalition for Health Care Reform, which I co-chair—would also displace workers from private insurance. That is a misconception. Employers would either purchase insurance directly for workers or help finance coverage indirectly—by enrolling employees in private insurance under public sponsorship and paying a payroll tax. Either way, employees and their families would be privately insured—and *all* would have coverage.

The American health care system is huge—bigger than the whole economies of all but six nations—and it's extraordinarily complicated. Sooner or later, we'll have to confront its problems head-on with a comprehensive reform that is equal to the task. I vote for sooner.

Robert Ray is co-chairman of the National Leadership Coalition for Health Care Reform and president of Blue Cross and Blue Shield of Iowa. He was the Republican governor of Iowa from 1969 to 1983.

EXHIBIT E

Cheaper Health Care (for the Rich)

By Henry E. Simmons

WASHINGTON

President Bush's proposal for health care reform, unveiled with much fanfare in February, is now making its way to Capitol Hill — piece by piece, and quietly. Two proposed bills — about insurance reform for small groups and tax deductions for the self-employed — were forwarded last week. Several more are said to be in the works. So far the plan has not caught on — in part, because it doesn't include reliable measures to slow the rise of health care costs; in part, because it doesn't specify how the annual cost of $35 billion would be financed.

But the fundamental political problem of the plan is also its main substantive shortcoming: It doesn't guarantee coverage for every American. As poll after poll makes clear, that is the one objective for health care reform that the public overwhelmingly supports, by margins of more than 4 to 1.

For Americans at or below the poverty level, the President's plan would provide tax credits to cover insurance costs. They would be worth up to $1,250 for individuals, $2,500 for married couples and $3,750 for families of three or more members.

Bush's plan won't help the uninsured.

Would these credits enable those without health coverage to buy it? Not at current insurance rates.

For individuals, the cost of comprehensive health coverage averages $2,100 a year — $850 more than a $1,250 tax credit. For families of four, coverage would typically cost more than $5,000 a year — at least $1,250 more than the proposed credit.

But let's suppose, as the Administration's plan does, that less expensive insurance packages would quickly be developed. The President's proposal would phase the credits in over five years, increasing them each year by the rate of inflation in the overall economy. Assuming a 4 percent annual inflation rate, a tax credit worth $3,750 this year would be worth $4,562 in 1997.

But the Commerce Department projects that health care costs will rise at least 12 percent a year over the next five years. So a family insurance policy costing $3,750 today, assuming one is developed, would cost at least $6,600 in 1997. To obtain coverage, the poorest families would have to come up with an extra $2,047 that year. That's just not in the cards.

For those above the poverty level — about two-thirds of the 35 million uninsured Americans — the plan would be of little help. The further their income rises over the poverty line, the smaller their tax credits would be. For those with incomes 50 percent higher than the poverty line, the tax credits would amount to only about 10 percent of the cost of coverage.

Uninsured families of very modest means would have to spend at least $3,375 a year on health insurance — money that most of them can't even conceive of piecing together — in order to get only a $375 tax credi This would keep them firmly in th ranks of the uninsured.

Taxpayers with higher income would not be given tax credits; rath er, they would be allowed to deduc health care costs from their pre-ta incomes, up to the same dollar valu limits that cap the tax credits.

But the value of a tax deductio depends on one's tax bracket. Thos in the 15 percent bracket would ge little more than half the benefit tha the more affluent taxpayers in the 2 percent bracket would receive. Thos who need more help would get les and with health care costs rising at 1 percent a year, their modest saving would be swamped by price increase early in the second year of the plan five-year phase-in period.

The President's plan contains som good ideas — about insurance rule malpractice reform and reduction c paperwork — that ought to be incluc ed in any comprehensive reforr package. But it would not give Amer cans what they most want fror health care reform: the assuranc that, come what may, they and the children will be covered.

Henry E. Simmons, a physician, is president of the National Leadership Coalition for Health Care Reform.

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EXHIBIT F

THE NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

PROPOSED BENEFIT PACKAGE

Overall deductible (person/family)	$200/$400
Annual out-of-pocket limit (person/family)	$1500/$3000
Hospital services (365-day maximum stay)	80% (20% co-pay)
Hospital alternatives (extended or home health)	80% (20% co-pay)
Surgical services	80% (20% co-pay)
Qualified provider services	80% (20% co-pay)
X-rays and laboratory	80% (20% co-pay)
Prescription drugs	80% (20% co-pay)
Essential emergency services	80% (20% co-pay)
Mental health care and substance abuse with a lifetime maximum	80% (20% co-pay)
Routine physicals/tests	80% (20% co-pay)
Well baby/child with vision, dental, & hearing	100% up to age 18

SOURCE: Report of The National Leadership Coalition For Health Care Reform: Excellent Health Care for All Americans at a Reasonable Cost, November 1991.

PREPARED STATEMENT OF THEODORE R. MARMOR

THE PROBLEMS OF AMERICAN MEDICAL CARE REFORM: THE CASE FOR UNIVERSAL COVERAGE AND SINGLE PAYOR FINANCING

1. The Risks of Apparent Consensus and Premature Compromise

American medical care, the media tells us regularly, is in serious trouble. Costs are too high, access and quality too variable. Indeed, there is relentless incantation about our $700 billion plus medical industry, consuming over 12 percent of our GNP, while failing to insure some 37 million Americans and leaving most of us one illness or one job change away from being medically uninsurable. These alarming numbers, moreover, emanate from all parts of the political spectrum. Most "liberal" commentators would accept the pro-market Heritage Foundation's declaration that "America's health care system is on the critical list and needs intensive care."

It is not clear, however, that the extraordinary agreement on these ills across party, occupation, income, region, and age will produce effective policy reform. For while this consensus permits (and may indeed generate) reform, it does not guarantee any particular remedy. Moreover, the remedies most widely discussed as probable are likely to reflect as much the current constraints on political action as the critical needs for health care improvement. Those constraints are of at least three types:

First, our political system alone makes the process of legislative change difficult. It is designed for delay, not actionas every civics book explains. It is also characterized by myriad and conflicting governments (federal, state, and local) and an abundance of policy entrepreneurs. The standard result is many proposals and no agreement on which to enact.

Second, what our institutions make difficult our ideological predilections make even more so. Historically, Americans have been ambivalent about government, turning towards it in dire need (the Depression, world wars) and spurning it in times of greed (the 1920s, the 1980s). For two decades, the nation's most prominent leaders have stressed government's liabilities, not its capacities. The media has amplified the mocking and one result has been continued erosion of American confidence that its public institutions can right the obvious wrongs of American life. The further result is that reformers in a problem area like health care are powerfully constrained in what they can propose without unleashing propagandistic attacks.

Finally, interests (and interest groups) further restrict our political maneuverability. America cannot finance medical reforms with "tax" dollars without the prospect of anti-tax dismay. This constraint popularly identified with Ronald Reaganis now embedded in the conventional wisdom of political reporting. It means that finding fig leaveslike patient charges and mandated health insurance coverage to hide the tax implications of universal health insurance is a full time occupation for many policy technocrats in Washington and the state houses. A related constriction affects how private health insurers are treated in most reform proposals. Maintaining jobs in that industry despite its widespread unpopularity among our citizens appears necessary if one is to avoid the unleashing of well-financed campaigns against Washington bureaucrats seeking to limit the supposedly desirable "pluralism" in the way Americans pay for their health care.

2. The Possibility of Bold Reform: Single Payor Models

These constraints have resulted in a view among politicians that bold reform specifically universal, single payor plans fashioned on the Canadian example is too ambitious. But polling data suggests the politicians are in fact too timid. One 1990 survey of ten industrial nations, for example, found Americans the least satisfied with their health care arrangements. Only ten percent thought our system "works pretty well." Eighty-nine percent agreed it needs either "fundamental changes" or "complete rebuilding." The publicbut not most of the special interest groups in medicine seems prepared to accept big changes. More recent polls show unequivocally that the American social ethic is not very different from that of other industrial democracies with universal health insurance. According to one, fully 83 percent of Americans "believe that the government should be responsible for health care for the sick." What these polling studies also show, however, is that Americans are ambivalent about whether governmental programs in health care can be administered without wasteful inefficiency.

Why is Canada's national health insurance (which they call "Medicare") so attractive to those advocating more far-reaching reform?

1. *Canada's economy, values and political institutions are similar to our own.* Like the United States, Canada is a large country with a highly urbanized and diversified market economy. Free enterprise and free spirits are valued. They have, like us, a federal system of government, with important powers (greater even than in the United States) reserved to provinces (the analogue to our states).

Every industrial nation in the world has adopted some form of national health insurance except the United States. All are happier with their health care systems than we are. If we are going to follow their example, it makes sense to look for models in those countries most like our own. An American system will have to be unique in many respects, but it would be foolish not to learn what we can from our neighbors.

2. *Canadian Medicare is responsive to local preferences and preserves freedom of choice while guaranteeing that every one has financial access to care without bureaucratic hassles.* Canadian Medicare is substantially financed and wholly administered by provincial governments. Provincial plans differ markedly from one another, reflecting local preferences. In fact, no province is required to provide health insurance benefits. It is the availability of federal matching funds (providing roughly 40 percent of provincial health care budgets) that has led them to do so.)

The federal government does not prescribe the details of provincial health care plans. But it does require that they embody five principles to receive federal funding. They must be universal (covering all citizens), comprehensive (covering all necessary hospital and medical care), accessible to all (imposing no deductibles or copayment obligations on individuals), portable (each province recognizing the other's

coverage), and publicly administered (under control of a public, non-profit organization).

These principles are intelligible to all Canadians, and they enjoy broad support. Physicians work for themselves rather than the government, and full patient choice of physicians is preserved. Canadians can go to any doctor they choose, as often as they and their doctor feel it is necessary. They never have to complete an insurance form for either hospital services or medical care. Physicians and hospitals never have to hound their patients for payment. There are no insurance claims adjusters looking over the shoulders of patients, and no "managed care" officials questioning individual treatment decisions.

Costs are contained through the provinces' control over aggregate budgets. If total billings by physicians exceed budgeted targets, physician fees are subsequently reduced. Hospitals (run by private not-for-profit organizations) operate on the basis of negotiated annual budgets rather than individual billings.

Budget negotiations between medical care providers and provincial health care administrators are periodic, noisy, contentious affairs but unlike the negotiations of private insurance companies and providers of "managed care" in the United States, they are out in the open for the public to see and are subject to public influence through the political process.

Provincial health administrators are constrained by the budget decisions of provincial parliaments. Hard decisions have to be made about how to allocate scarce dollars (e.g., do you fund more heart bypass operations or another well-baby clinic). Mistakes are made, but the provincial agencies are highly visible entities, accountable to the public for their decisions.

3. *Canadian Medicare has proved reasonably effective at controlling costs.* Before the introduction of universal health insurance in 1971, Canada financed its medical care the same way we did. They spent approximately the same percentage of their GNP on medical care as we did, and their costs were increasing at about the same rate as ours. Since then, Canada's health care expenditures in relation to their national income have somewhat flattened while ours have skyrocketed. Canada now spends thirty percent less of its GNP on medical care than we do, and the difference is growing.

4. *Canadian Medicare has met the test of public approval.* In the ten-nation survey mentioned earlier, Canadians were the happiest with their health care system. Fifty-six percent reported overall satisfaction compared to our ten percent.

It would be foolish to ignore Canada's example, just as it would be foolish to try to replicate it in every detail. American problems require American solutions, but we don't have to reinvent the wheel. Canadian Medicare offers an attractive, practical model for dealing with our medical care woes, and many of our political leaders know it. To remedy our shortcomings we need more pressure from the public and less special interest group propaganda.

3. The Political Economy of Single Payor Systems

There is, however, a complexity here that has not yet been fully explored. Single-payor systems have, at least by comparison with the current non-system in the United States, produced relatively more restrained health care expenditures in the last fifteen years. But what about the single-payor structure is at work? Why should this cross-national result be the case? Without knowing that, there is too much of a black box quality about the explanation. We have discussed the results so to speak, but not the reasons.

This is, of course, a complicated subject in political economy and I can only sketch out what I take to be the outline of an answer. But what I would emphasize is the distribution of the winners and losers from increases in health care expenditures. Everywhere among the industrial democracies, there are pressures to spend more on medical care; it is presumed, though with increasing expert dispute, that more medical care means better health. So the question is how expenditures for what is presumed social improvement are constrained? In pluralistic systems of finance, each payor is interested in her health costs, not the costs of health care. Any cost shifted represents a 100 percent gain to that payor; hence the competition in such systems to have someone else pay whenever possible. In the United States, that means attention to cost-sharing by patients (shifting costs backward), government requiring private insurance to pay Medicare benefits for certain retired workers (shifting costs sideways), and the reverse, as when companies reduce or eliminate their health benefits and turn employees into potential charity cases for local hospitals and doctors. Under such systems, total costs are reckoned at the end of the year, discovered, not chosen. The results are expensive, as the American experience testifies.

It also testifies for the single-payor solution of monopsony bargaining over the price and volume of health care in a political jurisdiction. Single payor systems rest on the notion that, because every marginal dollar of expenditure for health care is income for identifiable and organized health care providers, the payor side must have correspondingly concentrated interest in those marginal dollars to balance those stake-holders who regard each unit of expenditure as benefit, not a cost. The balancing of these interests does not mean health care expenditures will assume a particular level and stay there. But it does appear to provide the necessary conditions for establishing some equilibrium in expenditure levels. (Whether some system will emerge that can "harness" competitive forces to improve health care performance is at best speculative. What has emerged has not and Canada provides another illustration of the general type that throughout the industrial world has, in fact, restrained costs.)

The cost control question has been answered at the macro- level. At a micro-level, it involves the questions of medical care supply and payment details. The sharp increases in physician supply have everywhere strengthened the pressures for increased utilization and expenditures over recent decades. Other analysts have estimated that the Canadian physician supply has increased by over 70 percent, with the supply of physicians exceeding the growth in population by 2.3 percent per year. What is fascinating is that this rate of growth in physician numbers practically matches the increased per capita utilization of health care services over the same period. I must warn that a belief in the restraining effect on expenditure of excess numbers of physicians is a very serious expensive mistake.

What about hospital bed supply? Here, the Canadian experience is best thought of in connection with more recent American experience. The trend line of length of stay is downward in both the United States and Canada. But it is clear that there are very substantial variations in length of stay and therein lies a clear lesson for others wondering about how much to augment the supply of hospitals in advance of expanding financial access to care. The relevant lesson seems something like this: the reduction of the supply of hospital beds may well be the single most important prod to primary and preventive care that lies within a nation's range of policyrelevant tools. How long one must stay in hospital varies not just with the relevant medical condition but the availability of alternatives to hospital use. This is relevant not only to the beginning of lifebirthsbut to the treatment of the frail old. What Canada shows beyond doubt is that an ample supply of hospital beds, combined with increases in the old, produces a substantial increase in the use of hospital beds for what is nursing home care. (Beyond that, there is simply wasteful use of amply supplied hospital beds: eg., patients coming in one or two days before surgery to "get ready.")

Thus, it is appropriate to consider the redistribution of health care supply across communities. Perhaps it is safe to say that the huge distances and spread out population of Canada do not present obvious parallels to the circumstances of other nations.

Turning to methods of payment for health care, the global (as opposed to line-item) budgeting of hospitals as against the per diem or method of insurance funding that had been the pre-NHI norm in the west has been strongly endorsed. There are no panaceas here and each funding mechanism has the vices of its virtues. But among the virtues of global budgeting is ease in knowing what is committed to health careparticularly its most expensive component. Global budgeting in Canadian practice has involved a trade-off between the increased predictability (and controllability) of hospital spending and greater autonomy of hospital decision-making about how to spend the global budget. There are ample means in the Canadian system to restrain capital expenditures (separately budgeted) and additional means through decisions on operating costs that will be included in the global amount. But analysts seem now to agree that Canadian use of hospital beds (as opposed to the technological use rates within hospitals) has been unnecessarily ample. This is but one example that Canadian performance on health might be improved by less rather than more expenditure.

In sum the Canadian experience portrays a medical care system that works, that delivers decent care to an entire population at outlays that, while always pressuring decision-makers, are relatively stable and quite amazingly popular. If ever there was an example of a public institution that was both expensive and admired, it is Canadian national health insurance. None of these features depend on peculiarly Canadian values in politics, society, or economics. The particular institutional details do, of course, show their origins, but other nations could extract the essential features of the Canadian system and adapt them to their institutional architecture. Whether they would have similar effects depends on whether the new user differs

in some significant way from those nations whose practices conform to the Canadian pattern as well.

4. Conclusion

The reform of American medical care is indisputably high on the contemporary political agenda. The extraordinary consensus on the need for far-reaching changeranging across the ideological spectrumforeshadows policy adjustments in the 1990s. But it does not guarantee policy satisfaction at the end of the day. To find the right combination of effective and acceptable reform, we need to explore what our historical experienceand the lessons of other regimestells us about desirability and feasibility. In doing so, we ought to ponder the widespread use in other systems of politically accountable single-payor methods of financing care. And we ought as well to wonder why polities both similar to and different from our own have come to essentially the same conclusion about the necessity and acceptability of single-payor systems of countervailing power in modern medical care financing.

PREPARED STATEMENT OF SENATOR MITCH MCCONNELL

Mr. Chairman, I appreciate the opportunity to come before this Committee to offer my views on health care reform. This issue is clearly on the minds of Americans—just last month my office received over 500 letters on health care from constituents back home.

While no consensus exists on the path of reform our nation should follow, there is general agreement that high costs and limited accessibility are major problems associated with our current health care system. In Kentucky alone, some 700,000 people are uninsured or under-insured, and over half its counties have health professional shortages.

It is true America spends more on health care than any other nation in the world. In 1990, we spent $660 billion—a whopping price tag that amounts to $2 billion a day for medical care. According to some projections, this spending will continue to increase to a level that is excess of 16 percent of our GNP by the end of this decade.

Another grim statistic is that over 34 million Americans are without health insurance. Most are younger citizens, from poor and low income families. The good news is that 85 percent of Americans have some form of health insurance, and most are satisfied with the health care they receive.

There are no easy solutions to the health care crisis we now face. We cannot let business continue as usual, nor should we implement radical proposals that some of our colleagues have offered. In my opinion, we need to search for solutions within our current system. The prescription to this crisis must not have a crippling side effect on the quality health care most Americans enjoy today.

My views on reform are embodied in legislation I introduced in February 1991. S. 454, the Comprehensive American Health Care Act of 1991, strikes a balance between the extremes of business as usual and reinventing our system entirely. My bill addresses America's most urgent health care problems in what I feel is an appropriate and responsible manner.

Let me briefly explain the highlights of my health care plan:

EXPANDING HEALTH CARE ACCESS

To expand health care access for uninsured and underserved Americans, my plan takes a multi-pronged approach. First, it provides a tax credit for health insurance to low- and moderate-income families. Those who qualify could receive a credit of up to $1,750. Under my plan, the credits are graded according to income, with no credits extended to individuals who make in excess of $40,000 per year.

Second, my plan increases federal support for rural health care by eliminating the Medicare Part A reimbursement differential between urban and rural hospitals. Under current law, this differential is to be eliminated in FY 1995—my bill would speed up this process. Our rural hospitals must be placed on equal footing with their urban counterparts.

Third, I propose to revitalize the National Health Service Corps. There are currently 1,400 physicians and other health care professicnals serving in the Corps in areas that are underserved and economically depressed. By increasing funding for NHSC's scholarship and loan repayment programs—where the Federal government repays a portion of a medical students' loan in exchange for service in Corps—we can place more medical professionals in areas where they are desperately needed.

Fourth, my bill increases funding for Area Health Education Centers. These Centers provide continuing education and clinical instruction for physicians, nurse prac-

titioners and other health care professionals in medically underserved areas. AHECs provide an important incentive for health care professionals to settle in rural areas.

Finally, my bill allows county health departments to apply for federal grants to provide immunization services, maternal and infant care, health education and preventative health services. Our children—our nation's greatest asset—stand to benefit from expansion of these services, particularly as certain catastrophic diseases are once again on the rise. For example, specialists at the Centers for Disease Control recently determined that more cases of pertussis, or whooping cough, exist than were previously reported.

CONTAINING HEALTH CARE COSTS

To control the high costs associated with health care, my plan offers some needed reforms of the medical liability system. The fear of medical malpractice suits has adversely affected rural health care, curtailing prenatal care and delivery in many Kentucky counties.

The reforms I am proposing—abolishing joint and several liability, requiring anyone who brings a frivolous malpractice suit to pay part of the other side's legal costs, and encouraging alternative dispute resolution—are endorsed by the American Hospital Association and the American College of Nurse-Midwives, among others. According to a recent article in *American Medical News*, of the 1,003 physicians randomly selected and interviewed, 84 percent performed extra tests to protect themselves against malpractice suits. These costs, Mr. Chairman, are borne directly by patients and insurance companies.

My plan also requires the Secretary of Health and Human Services to review Medicare regulation of rural hospitals to determine how requirements could be made less administratively and economically burdensome. If there is one area of health care reform where I know a consensus can be reached, it is in cutting bureaucratic red tape.

LONG-TERM CARE

Finally, my plan addresses the most difficult problem facing America's seniors: the cost of long-term care. I propose a refundable tax credit to pay for long-term care insurance premiums. While all low- and moderate-income Americans would be eligible to receive the credit, assistance is targeted to be of the greatest benefit to our seniors. These credits vary according to income and age, with none extended to individuals at income levels of $40,000 and above.

Mr. Chairman, I ask that a detailed chart on long-term health insurance credit be made part of the hearing's record.

My bill also restores many of the important benefits lost in the repeal of the Medicare Catastrophic Coverage Act. Home health care coverage is expanded to a maximum of 38 days, and Medicare coverage would be provided from Home Intravenous Drug Therapy Services. Further, my plan deters deceptive insurance practices by requiring the Secretary of Health and Human Services to establish a certification system for health insurance for the elderly.

TAX CREDIT REFORM IS THE RIGHT APPROACH

I don't presume that S. 454 has the all the answers to our health care problems, but it is a step in the right direction. Some may ask, why tax credit reforms, why don't we just reinvent the whole system with our government as a central player? As Secretary of Health and Human Services Louis Sullivan warned the Senate Committee on Labor and Human Resources last March, reinventing our system and increasing the role of government in health care will only serve to subject "our health care sector to the whims and vacillations of budgets, politics, commissions and bureaucrats . . . ," which will have a direct impact on the quality care Americans have come to expect.

I don't have much faith in a "pay or play" reform approach either. When faced with a choice between paying an additional payroll tax or providing health benefits for their workers, many companies will opt for additional taxes, dumping workers on some form of public insurance plan. By some estimates, 51.7 million Americans currently covered under employer-based plans could end up on a public plan. The million dollar question—literally—is whether the additional payroll tax would adequately cover these workers health care needs.

The recent findings of Kentucky's Task Force on Health Care Access and Affordability demonstrates support for implementing change within our current health delivery system. Established by Governor Jones, the Task Force travelled throughout the Commonwealth last month and held 15 public hearings on health care reform. Their findings, which are to be reported to a special commission, include suggestions

similar to those I put forth in my bill—specifically, lowering costs through medical malpractice reform and expanding coverage in rural areas through incentives such as the National Health Service Corps.

Mr. Chairman, it is vital we improve our imperfect health care system. What can accomplish this is the same good old American ingenuity and commitment to excellence that has made medical care in our country the best in the world.

In closing, let me express my gratitude to the Committee for holding this important hearing today. While some members may disagree with the reforms I advocate, I know we share the same goal of expanding affordable, quality health care to all our citizens.

A HEALTH INSURANCE TAX CREDITS

Provides low and moderate income Americans tax-based assistance to purchase health insurance. Amount of credit is determined by income level and actual insurance expenditures. Credit is not available at income levels of $40,000 and above, and is made refundable to reach taxpayers below filing threshold. Health Insurance credit is reduced by the amount of health benefits received through the Supplemental Earned Income Tax Credit.

Income level	Credit
$20,000 and below to $24,999	$1,750
25,000 to $29,999	1,250
30,000 to $34,999	750
35,000 to $39,999	250

B. LONG-TERM CARE INSURANCE TAX CREDITS

Provides senior and other Americans with tax-based assistance to purchase long-term care insurance. Assistance weighted to provide most assistance to seniors, but all taxpayers are eligible to receive the credit, which varies by age and income. The credit is equivalent to the applicable percentage of qualified long-term care insurance premiums, subject to the dollar limitation. Credit is not available at income levels of $40,000 and above, and is made refundable to reach low-income Americans.

Age	Dollar limitation
More than 70	$3,000
More than 60 but less than 70	2,400
More than 50 but less than 60	1,800
More than 40 but less than 50	1,200
40 or less	600

Income	Applicable percentage
$20,000 and below to $24,999	70%
25,000 to 29,999	50
30,000 to 34,999	30
35,000 to 39,999	10

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

Mr. Chairman, I commend you for holding the first in a series of hearings on comprehensive health care reform. Today's hearing will focus on reform proposals that attempt to utilize the current employer-based system to assure access to affordable health care for all Americans.

Access to affordable, quality health care should be a right for all Americans, not merely a luxury for those who have the economic means to purchase health insurance. As many as 37 million Americans have no health care coverage, and millions more have insurance coverage which is inadequate to protect them against the cost of serious illness.

Furthermore, the rising costs of health insurance threatens coverage for all who are currently insured. Nearly one million Americans lose their health insurance coverage each year, often because their employers drop the coverage because of the ris-

ing costs of premiums or because insurers refuse to cover persons with pre-existing conditions.

The problem of the uninsured is not principally a problem of the unemployed—two-thirds of the uninsured are working persons or their dependents whose jobs do not provide health insurance.

I believe the most efficient and effective method of reaching these individuals and others who currently lack health coverage' is to build upon our existing public-private health care system. I believe an equitable system that assures access for all while controlling costs must ask every employer to share the responsibility of providing health care coverage for their employees and their dependents.

Last year, I and several of my colleagues on this Committee, introduced HealthAmerica—legislation that requires all employers to either provide private health insurance to their employees or contribute to a public program which will provide coverage.

Building upon the current employer-based system, our proposal guarantees employer sponsored coverage for all individuals affiliated with the workforce regardless of income. Our proposal also guarantees coverage for all individuals outside of the workforce through the creation of a new public program which reforms and expands Medicaid.

In order to reach the goal of providing quality, affordable health care for all Americans, this legislation has a budgeting and reimbursement structure which will result in significant reductions in the rate of cost increases throughout the system. The crisis in our nation's health care system is being fueled by the rapidly escalating cost of providing quality care to our citizens, so we must control costs to assure access.

While I believe HealthAmerica implements the necessary provisions to address the health care crisis of this country and reform our failing system, it is but one of many proposals.

Reforming the health care system will be a long and arduous task. Although, most of us believe there is a serious problem, few can agree on the solution.

We all must acknowledge, however, that the time to act is now. I urge my colleagues to examine these proposals carefully and continue their efforts to fix a severely broken system. I look forward to the testimony to be presented by today's witnesses.

PREPARED STATEMENT OF JOHN J. MOTLEY

Thank you for this opportunity to testify before the Committee on Finance on reforming the health care system by mandating that employers provide certain levels of health insurance or pay a new payroll tax to enroll their employees in a public health care program. The National Federation of Independent Business (NFIB) appreciates the opportunity to share with the Committee the data and conclusions we have accumulated on the small business health insurance market.

NFIB is the nation's largest small business advocacy organization, representing more than 500,000 small and independent business owners nationwide.

BACKGROUND

Health insurance was first cited as the number one problem for small business owners out of 75 potential problems in 1986 in the NFIB Foundation's survey, *Problems and Priorities.* Again in 1992, *Problems and Priorities* showed that the cost of health insurance is still the number one problem, but it is now twice as critical as number two, which is "federal taxes on business income."

An earlier foundation study, "Small Business and Health Care," found that small business owners want to offer health insurance as a fringe benefit out of both a sense of familial obligation and competitive necessity. Over two-thirds of NFIB member firms already offer health insurance. In general, these firms tend to be more mature, more profitable, and have more full-time employees than their counterparts that do not offer health insurance. Despite being fairly stable, these small firms experience high initial premiums and higher renewal premiums.

Two-thirds of those who do not now offer health insurance would do so if they could afford it. Their access to health insurance and quality health care is largely determined by affordability. The cost of health insurance can be the greatest payroll line-item in a small business—exceeding the combined cost of workers compensation and liability insurance. Between 1987 and 1991, the cost of health insurance for a single employee rose 79 percent and for family coverage, 72 percent. According to a poll by Foster and Higgins, the average per employee cost of health insurance in

1991 was over $3,500. For the typical small business, the figures are considerably higher.

The ability of the small business owner to provide insurance is influenced by the costs of premiums and the profitability of the business. According to "Small Business and Health Care," 91 percent of respondents reported that the cost of health insurance was becoming prohibitively expensive. For many small businesses, 20 to 300 percent annual premium increases, small profit margins, struggling regional economies, and restricted cash flow all contribute to the increasing difficulty small business owners have in purchasing health insurance.

In an attempt to retain coverage, almost all employers have tried spreading the pain by increasing employee deductibles and copayments. However, small business owners still tend to pay 100 percent of their employees health care premiums. Employers of all sizes have been trying to find ways to control and slow rapid premium increases. Larger firms have been able to turn to cost containment mechanisms including self-insuring and managed care arrangements. By virtue of their size, small businesses have very little access to managed care or other cost-containment measures. They are also unable to obtain the benefits of self-insurance and therefore must comply with expensive state mandates, pay state premium taxes, and shoulder a larger portion of the carrier's administrative expenses.

To the severe detriment of small business, the health insurance market was changed dramatically by the enactment of ERISA. Increasing health insurance costs, induced by the passage of ERISA, have forced almost 60 percent of the business community to self-insure to escape costly state regulation and taxes. This leaves small Main Street businesses who are not able to self-insure exposed to what is left of a distorted health insurance market. These small firms are subject to state mandates and premium taxes, medical underwriting, huge administrative costs, unilateral insurance company decisions, and high premium increases.

The market, so distorted, has led to aggressive underwriting, which artificially raises premiums as insurers seek to protect themselves from all foreseeable health risks. These practices induce premature and frequent changes from carrier to carrier, which in turn, leads to unforeseen adverse consequences, such as: preexisting conditions requirements imposed on new customers which can leave employees and owners without coverage for critical medical conditions; increased premiums each time a small business changes carriers in pursuit of lower premiums by increasing the carrier's administrative costs and by paying brokers' commissions; and frequent changes precluding the formation of small business associations or pooling mechanism.

There has been a growing consensus that past government actions have thrown both the health care and health insurance market into turmoil. While there remain strong differences of opinion on how to deal with health care and access for the uninsured, there appears to be broad agreement on the steps that need to be taken to correct the health insurance market. From 100 percent deductibility for the self-employed to insurance market reforms and from preemption of state mandates to small business insurance purchasing groups, there is agreement. Whether someone calls these changes "a first step," a "down payment on reform" or an "incremental solution," they need to be made now, in 1992 before the 102nd Congress adjourns.

For some time, these needed and agreed upon reforms have been held hostage by those who believe that they should only be included as part of a larger, more comprehensive solution, such as a "play or pay" approach. If the small business insurance market reform provisions are enacted by themselves, so the argument goes, the momentum for a more radical solution diminishes. Therefore, these changes need to be held back, as hostages, to extract business community or moderate support for the more radical approach.

The so-called comprehensive or universal solutions on either the left or the right, from "play or pay" to single payer to complete individual responsibility, do not have the support of the American people let alone a majority in Congress. Therefore, none of these more grandiose solutions can be enacted until the political debate is more mature. However, the business community, particularly the small business community, cannot wait that long. The status quo is no longer acceptable.

"Play or Pay"

Ninety-four percent of small business owners adamantly oppose a mandatory employer provision of employee health insurance, according to NFIB surveying. Employer mandates are administratively and financially burdensome. Small business owners do not believe that the government should interfere with the benefit decisions arrived at by employers and employees. "play or pay" will ultimately hurt employees who will find that they will be unable to negotiate with their employer when unique circumstances occur.

While the "play or pay" proposals vary, all would require employers to provide health insurance to their employees that work more than 18 hours a week or pay a 7 to 9 percent payroll tax. NFIB believes that the administration of a public system will cost more than the estimated 7 to 9 percent. In fact, the Small Business Administration estimates that the actual cost will be 12 percent of payroll.

The Minority Office of the Joint Economic Committee estimates that the direct costs of "play or pay" in the first year will exceed $87.8 billion. Yet, "play or pay" does not alleviate the high cost of providing health care, which is the primary reason small businesses do not offer it.

To pay for it, "play or pay" levies a substantial tax increase of $2,000—$3,000 on those who are least able to pay. The new tax burden will fall mostly on lower income employees who are at or near the bottom of the income scale through lower wages, reduced hours, and fewer employment opportunities or on employers who will forego earnings to pay it. This is a regressive tax for low income Americans who would effectively be paying the full cost of their health insurance.

If Congress carefully examined who is not now providing employee health insurance, they would find it would be small employers who are new or financially strapped. These small employers who offer health insurance less frequently than higher income firms, have a much greater proportion of hourly workers and have nearly three times as many low-wage workers as firms that offer health insurance.

According to an NFIB Foundation study, a direct tie exists between business profitability and the provision of employee health insurance. Over 90 percent of those taking more than $70,000 out of the business in the prior year provided employee health insurance, while only a third of those who took $20,000 or less out of the business did so. As business profitability increases so does the propensity for small employers to provide employee health insurance.

Study after study shows that millions of jobs would be put at risk if "play or pay" were enacted. For instance, COMSTAD Research Corporation concluded that 9.1 million jobs would be put at risk; the House Joint Economic Committee concluded that 712,000 workers would lose their jobs in the first year of implementation; and the Employee Benefit Research Institute estimates that between 200,000 and 1.2 million workers could lose their jobs as a result of an employer mandate.

While the numbers may differ they point to an unavoidable conclusion. A payroll tax is the most damaging tax that can be placed on new or financially unstable businesses.

It is important to understand that payroll taxes must be paid even before the first dollar is earned. They are not taxes on income; they are taxes on jobs. Today, employees and employers jointly pay 15.3 percent of the wage of every worker in FICA taxes alone. Added to this are unemployment insurance, workers compensation and other payroll taxes. Any increase in payroll taxes can only be paid for by hiring fewer workers.

An NFIB Foundation Study reported that if employers were mandated to contribute $150 a month per employee for health insurance, 26.4 percent would get out of business and 23.9 percent would let all employees go and continue operating.

The "play or pay" proposal is nothing more than a "Trojan Horse" for national health insurance. "Play or pay" will force many small business owners to place their employees into the public system. It will be cheaper to pay than play—providing employee health insurance will cost an employer more than the payroll contribution to the public plan—at least temporarily. However, at some point the payroll tax will have to increase because health costs will still be out of control.

In addition, NFIB is deeply concerned about the inclusion of standard plans, or even categories of coverage, in the "play or pay" proposal. while those being discussed do not mandate Cadillac plans that cover many of the most expensive treatments, they still will be priced beyond the ability of many small firms to pay for them.

Secondly, a standard plan set in law just begs to become the target of legislative gamesmanship. After all, that is how the current system developed over 800 mandates. While NFIB prefers to have the design of plans completely in the hands of insurers, basic plan options seem to be a workable compromise.

NFIB believes the "play or pay" approach for solving our health care crisis is ill-devised. It would be devastating to small employers and their low-wage employees and we strongly oppose it.

OTHER HEALTH CARE REFORM PROPOSALS

While the focus of this hearing is on the "play or pay" model for health care reform, NFIB will briefly comment on two other approaches being discussed in Congress.

Single Payer

NFIB members oppose a single payer system. They believe that a federally run program would substantially exacerbate the health care crisis. The government would have to substantially raise taxes, politically ration care and technology, and cut back on research and development efforts.

Countries that have national health care systems are also trying to reform their programs. They are experiencing escalating health care costs. They are stifled by a very rigid system that does not control utilization, and they are having to eliminate hospital beds, lay off health care workers, cap doctors income, and limit entry to medical schools. The Ontario Health Insurance Plan has allocated to hospitals a 2 percent increase for 1992 and a 1 percent increase in 1993 and 1994. What action did the hospitals take? In Toronto, 20 percent of the hospital beds were eliminated and additional beds are expected to be lost in the future.

In 1987 health care spending in Canada was 8.7 percent and 11.8 percent in the U.S. However, for over a decade Canada's economy has been growing about 2 percent a year faster than the U.S. economy. If inflation is excluded from the calculation, the rate of growth in per capita health care spending for both nations has been about the same—4 percent a year.

Why would the United States want to move in a direction that clearly would not alleviate spiraling health care costs? In fact, many of the countries that rely on a single payer system realize that their systems are in need of reform. They are even coming to the United States to learn more about managed care techniques.

The United States should not be considering a single payer system when it is clear that the future of such systems are in jeopardy.

Small Business Insurance Market Reforms

Since 1940, the number of people covered by public or private health insurance has increased from 40 percent to 84 percent. This success can be built upon and coverage can be increased through a combination of incentives, a return to market principles, and reforms of current law, supplemented with a new reliance on non-employment based insurance purchasing. Such changes taken together represent a persuasive and comprehensive approach to ensure that a significant number of Americans are covered by health insurance.

NFIB supports a health care reform package that includes the preemption of state mandated benefits, preemption of state anti-managed care laws, a low cost basic policy that can be marketed nationally, health insurance purchasing groups, 100 percent deductibility of health insurance premiums for the self-employed, restriction of the preexisting condition limitation, rating bands, guaranteed availability of health insurance policies, guaranteed renewability, risk pools, medical malpractice reform, health services and outcomes research, and simplification of health insurance administrative costs. These provisions taken together could reduce and stabilize the cost of health insurance for those who currently have it and for those that cannot now afford it.

NFIB recognizes that guaranteeing issue of health insurance to small business owners, restricting the preexisting condition exclusion, and limiting the variation in premiums between and within blocks of business will increase premiums for some. Yet, we believe that as a part of a balanced package, premiums will decrease for many and will stabilize for all. According to Aetna, only 5 percent of all cases would experience a 10 percent rate change if legislation such as Senator Bentsen's bill, S. 1872, was enacted and only 2.9 percent of total insured individuals would experience a cost increase greater than 10 percent.

A 1991 NFIB survey found that 73 percent of small business owners support guaranteed issuance of health insurance policies as a part of a balanced health care reform package despite the possibility that this provision could increase premiums. They believe that the insurance industry should be required to issue a policy to any business that wants to obtain coverage.

This Committee must understand that those in the private sector who oppose small business insurance market reform are generally the ones who are causing the problem. They are the ones who are insuring only healthy individuals, and they are the ones that are bringing employers in at a low premium only to substantially increase the premium six months down the road even without any claim submissions. Small business insurance market reforms will eliminate many of these unconscionable rating practices.

Conclusion

NFIB strongly believes that any health care reform bill must effectively address the most critical problems facing small business owners today, the cost of health in-

surance. Health care reform must stabilize the small business health insurance market and make available to small business owners affordable insurance choices.

The "play or pay" proposal is an ill-conceived approach to the health insurance coverage problem which will only exacerbate the current health care crisis. Health insurance coverage provided under "play or pay" proposes a massive new tax financed by those least able to pay--the working poor and near-poor—which includes small employers.

NFIB commends Chairman Bentsen for recognizing the need to reform the current system. Small business owners believe that small business insurance market reform is the beginning of the process of health care reform—it is by no means the end. They just ask for the process to get started by implementing reforms that will provide them access to affordable health insurance not only for their employees but for themselves and their dependents.

No one can afford to wait for the political debate to end, action—relief—must come now. We urge Congress to explore areas of agreement and move legislation that can be signed into law before the 102nd Congress adjourns. Thank you.

Attachment.

The NFIB Foundation

An Affiliate of
National Federation of
Independent Business

IT'S CHEAPER TO PAY THAN IT IS TO PLAY

A commonly discussed approach to resolving the health insurance coverage problem is "play or pay." The approach requires employers either to provide employee health insurance or to pay a fine/ tax/penalty. Revenues from the fine are then used to help de-fray the costs of providing uncovered employees with a speci-fied level of health insurance.

Many consequences of the play or pay approach and its generic parent, mandated coverage, are subject to debate. But one clear consequence of the approach, as currently proposed, is that it offers incentives for many, if not most, employers to pay the fine in lieu of providing employee coverage. As employers respond to the incentives provided, the incidence of private health insurance coverage will fall significantly and the revenues that the fines generate will be insufficient to cover public costs. Thus, play or pay substitutes public insurance for private at an unknown, but substantial cost, to the taxpayer.

The following observations are based on the specific provisions of S. 1227, HealthAmerica: Portable Health Care for All Americans Act. However, their tenor is equally applicable to Massachusetts' failed universal health care program and the fall-back position in Oregon's current experiment with tax incentives to small employers for providing employee health insurance.

Play or Pay?

Health insurance is expensive. Table 1 presents the employer's cost of health insurance (80% of the premium) for full-time employees as a percent of payroll by various sized per employee payrolls and per employee monthly insurance premiums. The monthly premium levels are total per employee premiums, including both the employer's and the employee's share. Note on Table 1 that the employer's share of an average premium for family coverage ($250 per month) for the average wage earner (just over $11/hr in wages and $15.50/hr in total compensation) is equivalent to about 8 percent of payroll. By comparison, the employer share of FICA (Social Security tax) is 7.65 percent.

Two points stare from Table 1. The first is that it is relatively more expensive to provide health insurance for lower per employee payrolls than it is for higher per employee payrolls. For example, the employer's share of a $250/month premium for a work force filled with minimum wage employees equates to somewhat less than 1/3 of average hourly payroll; for a payroll consisting of $12 to $12.50/hr employees, the employer's share equates to about 10 percent. The reason for the difference, of course, is that insurance premiums are fixed fees and do not change with wages. The consequence is that if compelled to provide coverage, employers would find it relatively less attractive to hire lower skilled (lower wage) employees and relatively more attractive to choose the pay option under a play or pay scheme.

Table 1
HEALTH INSURANCE PREMIUMS AS A PERCENT
OF PER EMPLOYEE HOURLY PAYROLL

Full-Time Employees (37.5 Hours/Week -- 52 Weeks/Year)
Employer's Share of Premium -- 80 Percent

PAYROLL/ EMPLOYEE/ HOUR	Per Employee Monthly Health Insurance Premium $100	$150	$200	$250	$300	$350	$400
$4.00	12.3	18.5	24.6	30.8	36.9	44.6	49.2
$4.50	10.9	16.4	21.9	27.4	32.8	39.7	43.8
$5.00	9.8	14.8	19.7	24.6	29.5	35.7	39.4
$5.50	9.0	13.4	17.9	22.4	26.9	32.4	35.8
$6.00	8.2	12.3	16.4	20.5	24.6	29.7	32.8
$6.50	7.6	11.4	15.1	18.9	22.7	27.5	30.3
$7.00	7.0	10.5	14.1	17.6	21.1	25.5	28.1
$7.50	6.6	9.8	13.1	16.4	19.7	23.8	26.3
$8.00	6.2	9.2	12.3	15.4	18.5	22.3	24.6
$8.50	5.8	8.7	11.6	14.5	17.4	21.0	23.2
$9.00	5.5	8.2	10.9	13.7	16.4	19.8	21.9
$9.50	5.2	7.9	10.4	13.0	15.5	18.8	20.7
$10.00	4.9	7.4	9.8	12.3	14.8	17.8	19.7
$10.50	4.7	7.0	9.4	11.7	14.1	17.0	18.8
$11.00	4.5	6.7	9.0	11.2	13.4	16.2	17.9
$11.50	4.3	6.4	8.6	10.7	12.8	15.5	17.1
$12.00	4.1	6.2	8.2	10.3	12.3	14.9	16.4
$12.50	3.9	5.9	7.9	9.8	11.8	14.3	15.8
$13.00	3.8	5.7	7.6	9.5	11.4	13.7	15.1
$13.50	3.6	5.5	7.3	9.1	10.9	13.2	14.6
$14.00	3.5	5.3	7.0	8.8	10.5	12.7	14.1
$14.50	3.4	5.1	6.8	8.5	10.2	12.3	13.6
$15.00	3.3	4.9	6.6	8.2	9.8	11.9	13.1
$15.50	3.2	4.8	6.4	7.9	9.5	11.5	12.7
$16.00	3.1	4.6	6.2	7.7	9.2	11.2	12.3

Chart 1 illustrates the pay option. The chart's X-axis depicts the average per employee hourly payroll. The Y-axis depicts the per employee health insurance premium as a percent of payroll. S. 1277 sets the initial fine, or the pay option, at approximately eight percent. The horizontal line represents the employer's relative cost under the pay option. It is a constant percentage. No matter what the level of the average per employee payroll, the tax is 8 percent of which the employer pays at least 4/5's. Thus, if the payroll for a group of full-time employees amounted to $1,000/week, the pay option would cost the employer $64/week (80 percent of the $80 fine) and employees $16/week (20 percent of the $80 dollar fine); if the same group of employees were paid $10,000/week, the em-ployer's share would be $640 and the employee's $160. Insurance premiums, a measure of the cost of health care, are irrelevant to the pay option and, therefore, do not appear on the chart.

Chart 1
EMPLOYER COST AS A PERCENTAGE OF PAYROLL
UNDER THE "PAY" OPTION

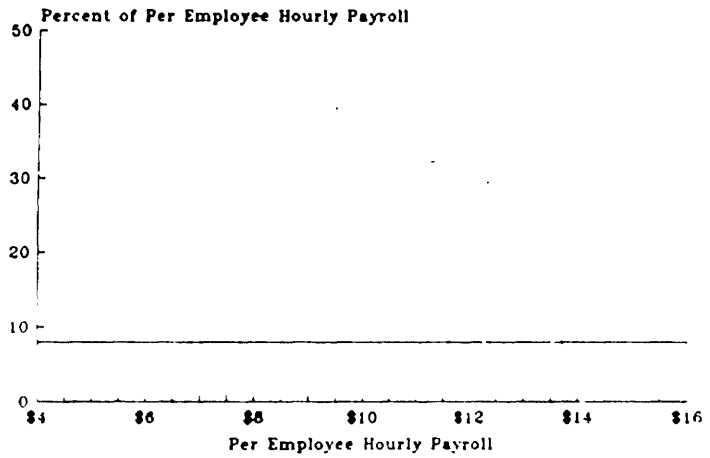


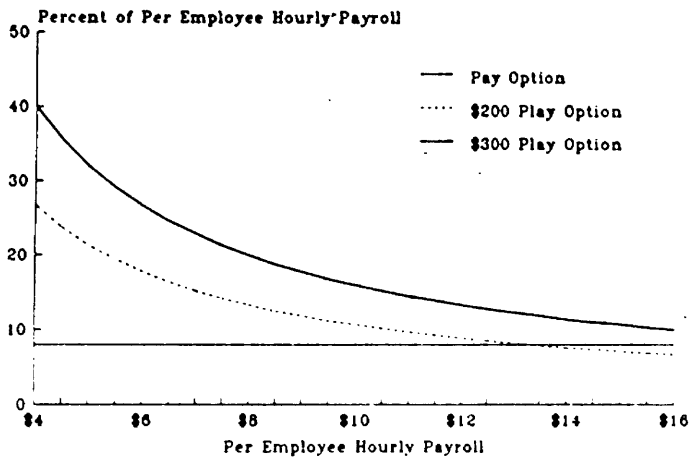
Chart 2 superimposes the play option on the pay option. Since the cost of health insurance is relevant to the play option, and since the costs of a minimum policy under S. 1277 can only be estimated, two premium levels -- $200/month and $300/month -- are presented. The levels were chosen because they fall on opposite sides of the current $250 monthly average, though the 20-30 percent annual growth in health insurance premiums implies both estimates are

conservative.

The curved, sloping lines on Chart 2 portray the play option at the two premium levels. Note that the dashed, sloping line representing the $200/month play option intersects the solid, horizontal line representing the pay option at about the $12.50/hour level. The intersection point means that on a payroll of full-time employees costing an average of less than $12.50/hour, the pay op-tion is the less expensive for the employer (and often for the em-ployee as well).

Should the premium be $300/month rather than $200/month, the incentive to choose the pay option is even greater. In fact, the heavy, sloping line representing the $300/month premium level does not even intersect the horizontal line on Chart 2. The intersection occurs somewhere off the chart, at a much higher level, about $23/hr or $45,000 a year.

Chart 2
EMPLOYER COST AS A PERCENTAGE OF PAYROLL
UNDER THE "PLAY" AND "PAY" OPTIONS



The second point staring from Table 1 is the relevance of the premium's size. A $150/month premium for an $9/hour per employee payroll equates to a little over 8 percent of payroll, but a $300/month premium for the same per employee hourly payroll amounts to 16 percent. Thus, the size of the premium becomes a critical factor in an employer's decision to play or pay, and there is every reason to believe the premium will be closer to $300/month than to $150/month.

The initial cost of the minimum benefit plan will largely be dictated by the benefit levels S. 1277 requires. It will subsequently be influenced by the cost containment measures in the legislation, the added demand placed on the health care delivery system due to the availability of new and greater health services, and the more rapid growth of health care prices than of wages. Thus, the legislated minimum as well as other measures affecting health care costs will significantly influence the pay or play decision.

Part-Time Employees

Employers hiring significant numbers of part-time employees, defined for present purposes as 17.5 hours per week, will be pushed even more sharply toward the pay option. Table 2 presents the employer's cost of health insurance for a payroll composed exclusively of part-time employees at different average per employee payroll levels and premium costs. The table was calculated to accommodate the S. 1277 requirement of a minimum 50 percent share for part-time employees rather than the 80 percent for full-timers.

Despite the smaller share of premium, note how the incentives to adopt the pay option are greater for part-time employees (Table 2) than for full-time employees (Table 1). A $250/month premium for a part-time employee costing $8/hour equates to 21 percent of payroll; for the identical employee working full-time, the figure is 19 percent. The same fundamental relationship among full-time and part-time employees occurs no matter what the level of wages or premiums. Thus, the incentives are to avoid part-time workers (75 percent of whom prefer part-time work), select the pay option, and reduce hours beneath some legislated minimum where health insurance mandates no longer apply.

Tax Incentives

S. 1277 provides tax incentives that effectively lower the premium cost. The most important of these tax incentives is a 25 percent credit on the first $3,000 of per employee premium for each full-time employee earning less than $20,000 per year. (The credit applies only to those firms with fewer than 60 employees.)

To assess the incentive effects of the credit, examine Table 3, a modified version of Table 1. A $20,000 annual income translates into payroll of about $11 per hour. Table 3 contains a horizontal dashed line located between $11/hour and $11.50/hour. The credit does not apply to an employee falling above (above in the sense of higher or more income) that line. A second, vertical line lies between the $250/month premium column ($3,000 annually) and $300/month column. It separates the premium sizes that would be eligible for an entire credit from those that would be eligible for a partial credit.

The credit's primary effect flows on those falling in the lower, left portion of the chart, i.e., left of the vertical line and

below (in the sense of lower income) the horizontal line. In other words, the credit's largest relative impact is on lower wage employees who have average to below average health insurance bene-

Table 2
HEALTH INSURANCE PREMIUMS AS A PERCENT
OF PER EMPLOYEE HOURLY PAYROLL

Part-Time Employees (17.5 Hours/Week -- 52 Weeks/Year)
Employer's Share of Premium -- 50 Percent

PAYROLL/ EMPLOYEE/ HOUR	Per Employee Monthly Health Insurance Premium $100	$150	$200	$250	$300	$350	$400
$4.00	16.5	24.7	33.0	41.2	49.5	57.7	65.9
$4.50	14.7	22.0	29.3	36.6	44.0	51.3	58.6
$5.00	13.2	19.8	26.4	33.0	39.6	46.2	52.7
$5.50	12.0	18.0	24.0	30.0	36.0	42.0	48.0
$6.00	11.0	16.5	22.0	27.5	33.0	38.5	44.0
$6.50	10.1	15.2	20.3	25.4	30.4	35.5	40.6
$7.00	9.4	14.1	18.8	23.5	28.3	33.0	37.7
$7.50	8.8	13.2	17.6	22.0	26.4	30.8	35.2
$8.00	8.2	12.4	16.5	20.6	24.7	28.8	33.0
$8.50	7.8	11.6	15.5	19.4	23.3	27.1	31.0
$9.00	7.3	11.0	14.7	18.3	22.0	25.6	29.3
$9.50	6.9	10.4	13.9	17.4	20.8	24.3	27.8
$10.00	6.6	9.9	13.2	16.5	19.8	23.1	26.4
$10.50	6.3	9.4	12.6	15.7	18.8	22.0	25.1
$11.00	6.0	9.0	12.0	15.0	18.0	21.0	24.0
$11.50	5.7	8.6	11.5	14.3	17.2	20.1	22.9
$12.00	5.5	8.2	11.0	13.7	16.5	19.2	22.0
$12.50	5.3	7.9	10.5	13.2	15.8	18.5	21.1
$13.00	5.1	7.6	10.1	12.7	15.2	17.8	20.3
$13.50	4.9	7.3	9.8	12.2	14.7	17.1	19.5
$14.00	4.7	7.1	9.4	11.8	14.1	16.5	18.8
$14.50	4.5	6.8	9.1	11.4	13.6	15.9	18.2
$15.00	4.4	6.6	8.8	11.0	13.2	15.4	17.6
$15.50	4.3	6.4	8.5	10.6	12.8	14.9	17.0
$16.00	4.1	6.2	8.2	10.3	12.4	14.4	16 5

fits. A smaller effect will be realized on those falling in the lower right portion of Table 3, i.e., lower wage employees with average to above average health benefits. The smaller effect stems from the credit's applicability to only the first $3,000 of per employee premium.

The credit's effect on those falling in the lower left portion of Table 1 is to reduce the health insurance premium as a percent of payroll by 1/4. For example, the employer's share of a $250/month premium on a $10.0/hr employee would decline from 12.3 percent to 9.2 percent. The credit in this case would not provide the

employer an incentive to chose the play option over the pay option. However, if the employer elected the play option, the credit would provide an incentive to retain low wage employees. The employer's share of a $150/month premium on a $7.50/hour employee would produce a different result. His share would decline from 9.8 percent to 7.3 percent. The credit in this case would serve to reverse the incentive from the pay option to the play option. The boxed area on Table 3 shows the limited range of wage and premium levels where the credit reverses incentives.

Table 3
HEALTH INSURANCE PREMIUMS AS A PERCENT
OF PER EMPLOYEE HOURLY PAYROLL AFFECTED
BY THE TAX INCENTIVES IN S. 1277

Full-Time Employees (37.5 Hours/Week -- 52 Weeks/Year)
Employer's Share of Premium -- 80 Percent

PAYROLL/ EMPLOYEE/ HOUR	Per Employee Monthly Health Insurance Premium						
	$100	$150	$200	$250	$300	$350	$400
$4.00	12.3	18.5	24.6	30.8	36.9	44.6	49.2
$4.50	10.9	16.4	21.9	27.4	32.8	39.7	43.8
$5.00	9.8	14.8	19.7	24.6	29.5	35.7	39.4
$5.50	9.0	13.4	17.9	22.4	26.9	32.4	35.8
$6.00	8.2	12.3	16.4	20.5	24.6	29.7	32.8
$6.50	7.6	11.4	15.1	18.9	22.7	27.5	30.3
$7.00	7.0	10.5	14.1	17.6	21.1	25.5	28.1
$7.50	6.6	9.8	13.1	16.4	19.7	23.8	26.3
$8.00	6.2	9.2	12.3	15.4	18.5	22.3	24.6
$8.50	5.8	8.7	11.6	14.5	17.4	21.0	23.2
$9.00	5.5	8.2	10.9	13.7	16.4	19.8	21.9
$9.50	5.2	7.8	10.4	13.0	15.5	18.8	20.7
$10.00	4.9	7.4	9.8	12.3	14.8	17.8	19.7
$10.50	4.7	7.0	9.4	11.7	14.1	17.0	18.8
$11.00	4.5	6.7	9.0	11.2	13.4	16.2	17.9
$11.50	4.3	6.4	8.6	10.7	12.8	15.5	17.1
$12.00	4.1	6.2	8.2	10.3	12.3	14.9	16.4
$12.50	3.9	5.9	7.9	9.8	11.8	14.3	15.8
$13.00	3.8	5.7	7.6	9.5	11.4	13.7	15.1
$13.50	3.6	5.5	7.3	9.1	10.9	13.2	14.6
$14.00	3.5	5.3	7.0	8.8	10.5	12.7	14.1
$14.50	3.4	5.1	6.8	8.5	10.2	12.3	13.6
$15.00	3.3	4.9	6.6	8.2	9.8	11.9	13.1
$15.50	3.2	4.8	6.4	7.9	9.5	11.5	12.7
$16.00	3.1	4.6	6.2	7.7	9.2	11.2	12.3

The credit's effect on those falling in the lower right portion of Table 3 is smaller and diminishes as the premium size increases. For example, the employer's share of health insurance on a $9.00/hr employee whose premium runs $300/month equals 16.4 per-

cent compared to 21.9 percent if the premium cost were $400/month. But, the credit is the same under both circumstances (25 percent of the first $250/month). The credit's effect, therefore, is to lower the former to 13.0 percent of per employee monthly payroll (a 21 percent reduction) while the latter's would drop to 18.5 percent (a 16 percent reduction). But in no instance does the credit reverse incentives. Incentives where premiums are above $250/month -- even with the credit -- always favor the pay option.

Most businesses have a broad range of wage levels. Since the play or pay decision is calculated from payrolls and the credit is calculated for single employees, the credit's effect is not as "clean" as outlined above. Even so, the following do occur: small firms hiring relatively more employees at less than $10/hour benefit more than those hiring relatively few at that wage -- though the credit does not change the incentive to hire fewer high wage rather than more low wage employees. Premiums under $250 per employee receive a relatively, though not necessarily an absolutely, higher tax subsidy than do higher cost health insurance coverage.

How Many Small Employers Impacted?

Table 3 shows that the employer's share of the average premium reaches 8 percent of payroll at the $15+/hr level on a full-time employee. The $15 figure translates into a business whose AVERAGE full-time employee costs (with fringe benefits and payroll taxes) nearly $30,000 a year. How common is a small business payroll averaging $15 per hour or less? Or, how common are firms that devote more than 8 percent of its payroll costs to health insurance?

A senior consultant for Noble Lowndes recently asserted that the cost of corporate health care in 1990 was 14 percent of payroll, up from 5 percent in 1980 (see, Business Insurance, June 21, 1991). For smaller firms, the situation is less clear but no less disturbing.

A survey conducted by The NFIB Foundation in early 1990 found that 63 percent of small employers reported covering at least some of their employees (Small Business and Health Care: Results of a Survey). About 38 percent reported covering all. Since S. 1277 requires coverage of most employees, Table 3 shows the employer's share of health insurance as a percentage of payroll only for those firms covering everyone. (The bill exempts new firms and employees working less than 17.5/hrs/week.) Note that in 1989, 40 percent paid health insurance premiums in excess of 8 percent of payroll and 1/5 paid in excess of 10 percent. But, the cost of health insurance has risen by 1/3 to 1/2 since that time. Such increases would have pushed an even greater proportion of these owners toward the pay option. The increases also slide a substantial number of those formerly paying 7 to 8 percent of payroll into the above 8 percent range. Thus, between 50 and 60 percent of those now covering all employees pay more than 8 percent of payroll for employee health insurance.

What if the 3/5's who cover only some of their employees or don't have coverage are required to play or pay? Are they any different than those who cover all employees with health insurance? The answer is "yes." These people generally own businesses which do less well, meaning fewer employee benefits, lower wages and lower business earnings. Refer back to Table 1. It shows that the play option costs relatively more on lower wage employees than on higher wage employees. Thus, those with only partial coverage or no coverage, the 3/5's not included on Table 4, would usually find the incentives to pay even stronger than would those who provide coverage for all. The principal exception probably would be those too financially weak to continue operation.

It does not follow from these data that half of the small business population would today find the 8 percent penalty financially more attractive than purchasing insurance. The tax credit, which would lower that proportion, cannot be calculated from the numbers available here because the credit only applies to certain lower-income employees. We don't know which firms had low-income employees at the time of the survey and which did not. In addition, only the employer's premium cost, not the total cost, was obtained. S. 1277 could force the employer's current premium share higher thereby making the pay option more attractive for those who now pay less than 8 percent of payroll. Yet, it could also provide a cushion for those now paying more than 80 percent of the total premium, allowing them to cut back to the 8 percent penalty level.

Table 4
SMALL EMPLOYER'S COST OF EMPLOYEE HEALTH INSURANCE AS A PERCENT OF PAYROLL - 1989
(Employers Covering All Employees Only)

PERCENT OF PAYROLL	PERCENT OF EMPLOYERS
< 4	19
5 - 6	18
7 - 8	18
9 - 10	20
> 10	20
No Answer	5
	100

Despite these uncertainties, what can be said is that huge numbers of small businesses would find it in their financial interests to choose the pay option. Even if the parameters were as wide as 25 percent on the low end and 50 percent on the high, the difference would amount to between one and two million small employers who would find it cheaper to pay than to play.

Raising the Fine

One possible means to eliminate or reduce the incentive to choose the pay option is to raise the fine. Charge more than 8 percent; charge 10 percent or even 12 percent. S. 1277 keeps this option open by giving the Department of Health and Human Services the constitutionally questionable power to set the fine (tax).

A higher fine would reduce the proportion of small business owners choosing the pay option, and thereby reduce the overall public subsidy. Return to Chart 2. Raise the horizontal line (the pay option) from its current 8 percent to 10 percent. The $200 play option now intersects the pay option at about $9.50/hr; the $300 play option intersects the pay option at $14.50/hr. Raise the horizontal line again. This time raise it to 12 percent. The $200 play option intersects the 12 percent pay option at about $8/hr and the $300 play option intersects it at about $12.50/hr.

The pay option is less attractive under the 10 percent scenario than when the fine was 8 percent. It is even less so when the fine is 12 percent. But, given average wage levels and escalating health care prices, huge numbers of small employers would still have a strong incentive to pay rather than play. For example, a business owner with a workforce consisting of $10/hr, full-time employees whose health insurance premiums are average and who uses the tax credits of S. 1277 would currently find the play option marginally more attractive than a 10 percent pay option. If the insurance premium rose 20 percent next year -- and that is not unreasonable -- the incentives would be reversed. Thus, even if the fine were pegged at 10 percent, small business owners with firms populated by somewhat lower than average wage earners and who understand that health costs will rise faster than wages would rationally opt to pay.

The consequences of a higher fine will be even more pronounced for low-wage and part-time employees than it otherwise would. The fine already falls heavily on these workers because they are the ones who eventually must pay it in the form of lower wages and fewer job prospects. Raise the fine, and wages and job prospects decline further. Thus, low-wage and part-time employees as a group will be in the ironic position of subsidizing health care for many people with more income than theirs.

Conclusion

The incentives in the play or pay approach to health insurance coverage for a significant number of employers are to pay. They are particularly strong for employers hiring unskilled and part-time workers. A small business owner with 8 employees at $9/hr and 2 part-time employees at $6.50/hr, for example, could cut health care costs in HALF (from an average premium) by paying the fine.

Moreover, since small employers pay as much as 20 percent more for the same coverage as do large employers, small business employ-

ees could enjoy relatively greater benefits in the federally subsidized program even when employer costs are the same under the play and pay options. Greater relative benefits is the second incentive pushing small business owners to the pay option. The third incentive is elimination of the "hassle" of shopping for and purchasing insurance, and acting as the mediator between the insurer and employees.

Financial considerations are the primary reason many small business owners do not now purchase employee health insurance. With health care costs rising faster than wages, small employers will find it increasingly difficult to maintain current coverage, let alone expand it. The incentives in S. 1277 push small employers in the same direction, only harder. S. 1277 will encourage many employers to drop existing private employee health insurance packages and to not purchase new ones, by offering a more financially attractive Federal alternative. Thus, it is likely that a huge number of small business owners, perhaps a majority, will elect the pay option. And, if huge numbers select the pay option, S. 1277 effectively begins a Federal take-over of private health insurance, offering the unhappy prospect of a nationalized Medicare-type public insurance system replete with uncontrolled costs.

The NFIB Foundation

An Affiliate of
National Federation of
Independent Business

TAXES BASED ON THE INABILITY TO PAY: ANOTHER EFFECT OF "PLAY OR PAY"

Mandatory employer provision of employee health insurance is a tax levied on those least able to pay. Whether the tax is direct ("pay" option) or indirect ("play" option) depends on an employer's choice. But in either case, the effect is the same -- a large, new tax liability that must be paid principally by those who can least afford to do so. That is true whether one assumes the new tax burden falls on employees through lower wages and fewer employment opportunities, or on employers who will forego earnings to pay it. Unfortunately, the negative redistribution effects of "play or pay" have gone largely unnoticed in the current debate, mocking the re-distribution concerns lying at the political heart of the vigorous debate over the so-called middle income tax cut and various other issues.

It is well-known that working Americans without employer spon-sored health insurance usually fall near the bottom of the income scale. If one believes that these low income Americans would ef-fectively pay the full cost of their health insurance under "play or pay," as do most economists, then the proposal is by definition regressive. The reason is that the proposal for all intents and purposes levys a substantial tax increase ($2,000 - $3,000 a year) almost exclusively on the working poor and near-poor. However, if one believes that employers will absorb the increase by reducing their income, as do many social activists, then regressivity may not be an issue.

The following paragraphs demonstrate that one's belief about who ultimately pays the cost of a "play or pay" health insurance program is irrelevant to the regressivity discussion. They show that even if employers do absorb program costs, or even a fraction of their costs, "play or pay" remains a highly regressive approach to resolution of the health insurance coverage problem.

Business Profitability and Employee Health Insurance

A direct tie exists between business profitability and the provision of employee health insurance. Owners who take more out of their businesses in the form of salary, earnings, draw, etc., are more likely to provide employee health insurance, while those who take out less income are less likely to do so. In fact, a 1989 survey conducted by The NFIB Foundation found that over 90 percent of those taking more than $70,000 out of the business in the prior year provided employee health insurance.[1] Just a third of those who took $20,000 or less out of the business did so.

Exhibit 1 presents the direct relationship between income from the business and provision of employee health insurance. The data create an almost stair-like pattern. As business income rises in $10,000 increments, the propensity for small employers to provide employee health insurance rises as well. In other words, where businesses are relatively profitable, small business owners tend to provide health insurance as an employee benefit. Where businesses are marginally profitable, small business owners tend not to.

"Play or pay" demands that all employers not currently providing employee health insurance make a significant financial contribution to the health care costs of their employees. But who is not now providing health insurance? Those drawing comparatively little from the business are the ones usually not providing the benefit. Therefore, if one believes that employers will bear the cost of a "play or pay" program, the burden absorbed by employers primarily will fall on the group least able to afford it. Under these circumstances, the financing system of "play or pay" is regressive.

Critical observers might question the validity of the self-reported income figures used to make the association found on Exhibit 1. They might also wonder about the bar on Exhibit 1 labeled "N/A," noting that only 61 percent of the "N/A" group provided employee health insurance. Those observers could reasonably ask how large this group of respondents was and where did its members fall on the "take-out" scale. The short answers to these two questions are that a check within the survey indicates that the income data are reliable and that the "N/A" group reflected the distribution of the income data across the reporting population. The following section addresses those data reliability questions. Readers not wishing to review these data nuances should skip the section and proceed to the section on owner income and business size.

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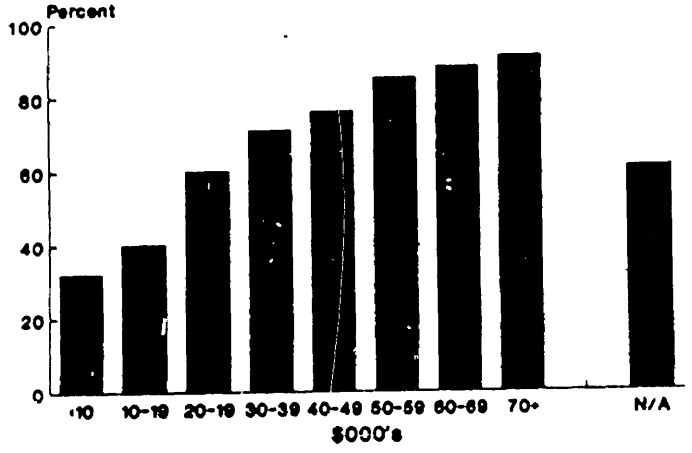
[1] Hall, Charles P., and Kudor, John M., *Small Business and Health Care: Results of a Survey*, The NFIB Foundation: Washington, D.C., 1990.

Check on the Reliability of Income Data

The income question ("About how much did you take out [salary, draw, earnings, etc.] of your business last year?") appeared at the very end of the survey. It provided respondents possible answers in $10,000 increments up to $70,000. In addition, the query offered a "Prefer Not To Answer" option. These broad ranges were designed to provide respondents with a degree of comfort in reporting a private matter that narrower ranges or actual dollars figures would not have. As it was, 19 percent chose the "Prefer Not To Answer" option and five percent left the question blank.

Exhibit 1
SMALL BUSINESS OWNER "TAKE-OUT" AND THE
PROPENSITY TO PROVIDE EMPLOYEE HEALTH INSURANCE

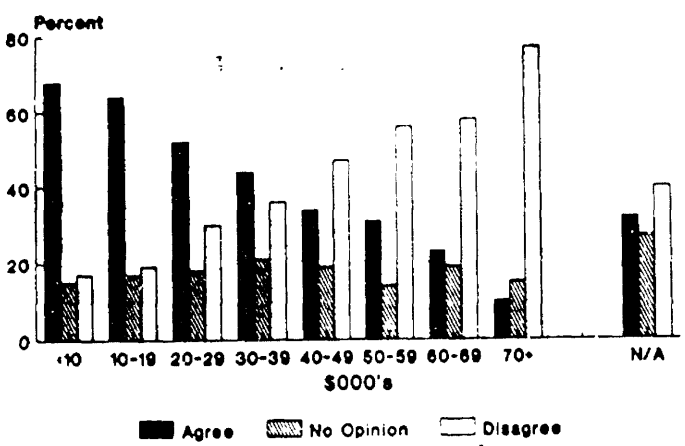


A check on the income inquiry was included earlier in the survey. It was designed to uncover similar, though not identical, data, and to provide a comparative point for the income question. The check query posed the following proposition, "I could earn more working for someone else than in this business." Respondents could answer on a five point scale ranging from "Strongly Agree" to "Strongly Disagree." Factors such as personal opportunity costs, newness of the business, etc., would affect agreement or disagreement with the proposition. However, financial success of the business should be the most prominent factor in the assessment.

Note the close relationship exhibited on Exhibit 2 between the belief that an owner could earn more elsewhere and low take-out, i.e., earnings. More than 2/3's of those reporting take-out of $10,000 or less agreed that they could earn more elsewhere. At the other end of the scale, over 3/4's of those reporting take-out of $70,000 or more did not believe they could earn more elsewhere. The chart's bars are, in fact, almost symmetrically positioned. As income rises, the percent disagreeing rises and the percent agreeing falls. As income falls, the opposite occurs. The correlation between the answers to both questions is very high. Moreover, the point where more begin to disagree with the proposition than agree with it comes at $40,000, just about the point of median family income for a family headed by someone with above average education and in their 40's. As a result, the data are mutually reenforcing and suggest reasonable reporting accuracy.

Twenty-four (24) percent of survey respondents failed to answer the "take-out," i.e., income, question. This group conceivably could be loaded with owners doing very well, yet providing employee health insurance infrequently. On the other hand, it could be loaded with those who are not doing well, yet offering insurance far in excess of their means. One way to address the issue is to cross-reference (cross-tab) the check question with the 24 percent who didn't answer the income question. If a comparatively large percentage of the non-respondents disagreed with the notion that

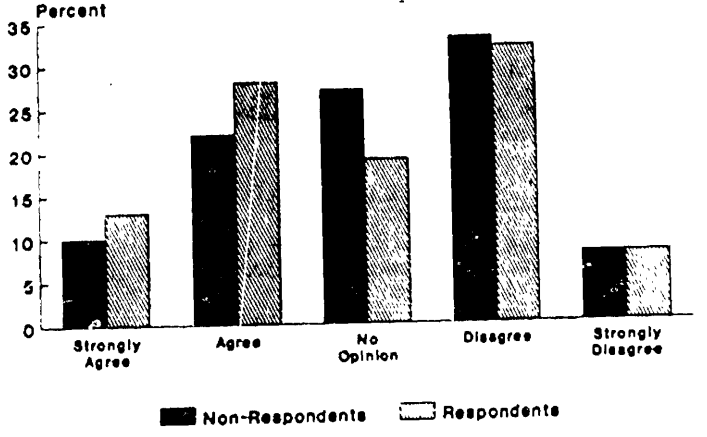
Exhibit 2
AGREEMENT WITH THE PROPOSITION THAT "I COULD EARN MORE WORKING FOR SOMEONE ELSE THAN IN THIS BUSINESS BY REPORTED 1989 BUSINESS TAKE-OUT



they could earn more elsewhere, then we might conclude the group is heavily (and disproportionately) populated by those doing well. The opposite would also be true.

Exhibit 3 demonstrates remarkably little difference as measured by the check question between those who answered the income question and those who did not. The two populations are the same for all intents and purposes. The small difference that did exist suggested that non-respondents do somewhat better than respondents. At the same time, non-respondents did not offer insurance as often as did respondents (63 percent versus 60 percent). The cumulative effect is to modestly reduce the slope of the increases in insurance provision as take-out rises. In other words, small business owners with relatively low take-outs are somewhat more likely to provide employee health insurance than the data on Exhibit 1 suggest. The opposite is also true. Yet, the fundamental relationship is unchanged. Those doing comparatively well exhibit a high propensity to provide employee health insurance, while those with doing comparatively poorly exhibit a high propensity to provide none.

Exhibit 3
RESPONDENT AND NON-RESPONDENT TO THE INCOME SURVEY QUESTION BY AGREEMENT/DISAGREEMENT WITH THE PROPOSITION THAT THEY COULD EARN MORE WORKING ELSEWHERE



Owner Income and Business Size

W. David Helms, President of the Alpha Foundation, a Washington-based health research and consulting organization, observed that the health insurance coverage "problem is with the very small employer, or the micro-employer," i.e., businesses with less than 10 employees.[2] He noted that half of the employed uninsured could be found in firms of less than 10 employees and another 18 percent in firms of 10-24. How does this phenomenon relate to an employer's financial capacity to provide employee health insurance benefits?

The smallest employers not only are the ones who least often provide employee health insurance, they are also the ones who take least out of their firms. Examine exhibit 4. It presents owner take-out by size of firm. Note the employee size of business Helms identified as the "problem." Forty-five percent of those who owned firms with 1-4 employees reported taking-out less than $20,000 in 1988. That percentage falls almost by half when moving to the next largest size classification, i.e., the 5-9 employee group. Still almost one in four took less than $20,000 out of their businesses. The percentage of those who took out less than that amount falls rapidly as the businesses size increases. The opposite occurs as well. Relatively few owners of businesses employing 1-4 people took $60,000 or more out of the business. The same is true of those owning businesses with 5-9 employees, but the percentage rises along with firm size.

The data presented in Exhibit 4 provide corroborating evidence of the blatantly regressive nature of the "play or pay" proposal under the assumption that employers ultimately absorb the cost. We already know that the proposal is regressive if the employee ultimately aborbs the cost. But, if "play or pay" is also regressive when the employer absorbs the cost, shouldn't those people sensitive to the concerns of the less-fortunate be appalled at the scheme? It would seem so. Yet, many are not. How can that inconsistency be resolved?

A Regressive Tax or a Simple Premium?

An argument can be made for "play or pay" recognizing that the financing mechanism is regressive. The argument runs that those paying the bills, i.e., the formerly uninsured, effectively are also those receiving the benefits. Thus, the tax is really not a tax at all. It is merely a premium paid for health insurance, and good social policy requires that everyone have health insurance. Regressivity is not an issue under these circumstances.

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[2]W. David Helms, "Experiments with Incentives for the Smallest Employers," *Rescuing American Health Care: Market Rx's*, The NFIB Foundation: Washington, 1991, p. 50.

Exhibit 4
OWNER TAKE-OUT BY EMPLOYEE SIZE OF BUSINESS

Employee Size of Bus	% of Total Population	Income from Business <$20	$20-39	$40-59	$60+
1-4	52	45	36	12	7
5-9	23	24	40	23	14
10-19	13	15	38	26	22
20-49	8	10	24	26	40
50+	4	4	15	16	65

Population totals from SBA data, 1991

That argument is supported by the nearly five million people who purchase non-group health insurance with under $15,000 in annual income, or the nearly ten million who purchase it with less than $30,000.[3] This group manages to purchase health insurance on modest incomes. Others can as well. Add tax credits for the very poor and some real progress can be made on the non-coverage problem.

If that argument were to be made, no reason exists for small employers, those most effected by "play or pay," to be included in the process. Conventional wisdom holds that small employers bring group economies to their uninsured employees if nothing else. There is some truth to that argument. But we also know small business owners already pay substantially more for the same coverage than do larger insured units. The participation of the small employer, therefore, serves to raise the premium for the low-income insured by requiring the employee's participation in a small rather than a large group. It would be much simpler, fairer and cheaper to fashion large purchasing groups, by-passing small employers, and eliminating the need for a "play or pay" scheme.

Conclusion

Most economists argue that employee benefits are paid by employees in the form of lower wages and less employment. That means health insurance provided under "pay or play" would be financed by the people that would receive coverage. Thus, the working poor and near-poor would receive the benefit, but they also would pay the bill. A strong argument can be made for that position -- those who

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[3]Helms, *op cit.*

receive benefits should pay for them. Yet, it is precisely because the poor and near-poor usually cannot pay for their insurance given other financial demands that a coverage problem exists.

Adding a significant financial burden to the working poor and near-poor bothers many people. But even if employers ultimately bore the cost of health insurance, nothing would change. A serious regressivity problem would remain. Small employers who do not provide employee health insurance are also the ones who take comparatively little out of their businesses. They, too, are often part of the working poor or near-poor. To tax them to provide the health insurance for other members of the working poor or near-poor makes no more sense than simply requiring the poor to purchase insurance. In fact, it makes less sense because the marginal employer would usually have to absorb the costs of more than one person/family, making the tax all that more severe.

Most "play or pay" proposals do incorporate tax credits or subsidies of a similar nature. Those credits are intended to ameliorate some of the most egregious regressivity inherent in the "play or pay" approach. But, to increase the credits sufficiently to eliminate, or nearly eliminate, regressivity abandons "play or pay" as an approach. To purge the credits puts an extreme burden on the working poor or near-poor whether they be employees or employers. Thus, the inclusion of credits in "play or pay" legislation primarily functions to acknowledge and underscore its liabilities.

"Play or pay" is an ill-devised approach to the health insurance coverage problem. The plan proposes a huge new tax. And, the huge new tax would be apportioned on the inability to pay. There are better ways to finance health care.

PREPARED STATEMENT OF ALAN PERES

Mr. Chairman and members of the Finance Committee, I am Alan Peres, Manager of Benefits Planning, Ameritech Corporation. Ameritech is a telecommunications and information services company headquartered in Chicago. Ameritech has 75,000 active employees and over 45,000 retirees. The cost of providing coverage to this group and their dependents exceeded $410 million in 1991. Accompanying me is Sharon Canner, NAM's Assistant Vice President for Industrial Relations.

I am pleased to appear today on behalf of NAM's 12,500 member companies, 8,500 of whom have fewer than 500 employees. Over 97 percent of these firms, according to a 1989 survey, provide coverage for both their workers and dependents, but the future of such coverage is threatened by staggering cost increases which cannot be sustained.

We commend you, Mr. Chairman, for convening this hearing today to explore solutions to this problem, the related issues of quality and access and for raising the level of debate by introducing S. 1872 in 1991. NAM believes that S. 1872 is an important first step toward health care reform and we strongly supported S. 1872 during committee markup and in subsequent floor action.

While there is widespread agreement on the need to improve access and cost control, there is widespread disagreement on the means to achieve those ends. However, we cannot afford to wait for full consensus while costs continue to escalate In the meantime we should enact certain incremental market reforms such as those proposed in S. 1872. Further, forging ahead with a major restructuring of the health care system is risky, given the difficulty in anticipating the effects of reform on a very complex financing and delivery system.

This testimony will make general comments on national health insurance proposals—S. 2320, S. 1446 and S. 2513—introduced by Senators Wellstone (D–MN), Kerry (D–NB) and Daschle (D–SD), respectively, discuss the Canadian system and offer observations on the philosophical approach of single payer national health in-

surance programs. We will also offer NAM's recommendations on health system reform.

PROPOSALS FOR A NATIONAL HEALTH INSURANCE PROGRAM

We appreciate the thoughtfulness and hard work which went into the development of S. 2320, S. 1446 and S. 2513 by Senators Wellstone, Kerry and Daschle, respectively. These bills aim to achieve universal coverage through use of a social insurance financing mechanism. They take different approaches to governmental administration, private sector involvement in delivery and financing, and cost-sharing by individual citizens. Consumer cost-sharing, as shown in studies such as the Rand Corporation health insurance study, does reduce utilization as well as control plan costs. In fact, several Canadian provinces are now considering cost-sharing (no cost-sharing is currently permitted in Canada) as a means to reduce their governmental outlays.

None of the three plans presents a clear proposal for medical liability tort reform and its relationship to defensive medicine costs, which are estimated to add 10 to 20 percent to health costs yearly. S. 2320 makes no mention of liability tort reform, S. 1446 leaves the recommendations for reforms to a national commission and S. 2513 would make grants to states on medical liability reform.

Our purpose today is not to discuss the merits, or take issue with any one bill, but rather to address an issue of greater concern—the philosophical approach of a government-administered system of health care.

THE CANADIAN HEALTH CARE SYSTEM

The single payer system with which Americans are most familiar is that of Canada. Over the past few years volumes of information on the Canadian health care system have been published in scholarly journals, and in newspapers and magazines. Programs frequently appear on radio and television.

Generally, this information focuses on the advantages and disadvantages of the single payer Canadian model without discussing the legislative, judicial and cultural underpinnings which make that system work in Canada. Only when those factors are clearly understood can we determine whether that system, or parts of it, is the right approach for the United States.

Many Americans learn about the Canadian system from study tours and from reading articles. Some have spent a couple days in Toronto, but Toronto is no more typical of Canada than the Lower East Side of Manhattan is of the United States. Toronto is the richest part of the richest province. However, to truly understand the important subtleties of this system, one must spend considerable time living in that country. I lived in Canada for 13 years and worked in the health system for 7.

People often speak of the Canadian health care system as if it were a monolith. It is not. There are 10 provincial and 2 territorial systems. While the provinces must meet certain federal guidelines for cost sharing, even those guidelines are sometimes bent or ignored. As the Canadian government implements its announced intention to reduce to zero its health block grants, more significant interprovincial differences may occur, particularly in the less prosperous provinces.

Cultural and Political Differences. Canada is geographically a huge country. Most people, however, live near the U.S. border. It is our largest trading partner, yet largely overlooked by many Americans. There are differences and they are significant. Some of those may be as important to the control of health care costs in Canada as the social insurance single payer system itself.

In 1966, the United States Supreme Court handed down the Miranda ruling, requiring police officers to inform people arrested of crimes of their constitutional rights. This change was quickly adopted by American television shows about police. At that time, Canadian television was dominated by American-made shows. The result was an expectation that people arrested in Canada must be "Mirandized." No such right, however, exists in Canada. It is likely that no American watching a show about Canadian police would even notice that arrests were not accompanied by suspects being "Mirandized."

There are many factors which contribute to the success of the Canadian health care system. Single payer is but one of them.

The Canadian system of government is the most notable. It is a parliamentary system of government. Responsibility and accountability rests with the Minister of Health in the respective province, as health care is a provincial responsibility. The minister not only makes policy, but implements it as well. That individual must publicly defend the actions of the ministry before the provincial parliament. Laws are passed because the party in power wants them passed. Through party discipline, the prime minister or provincial premier generally prevails in achieving his or her

political goals. Party discipline is relaxed in few instances where members are allowed to vote their consciences.

The government controls no! only the health system, but the education system which prepares new physicians and other professionals at the undergraduate, graduate, post-graduate and residency levels. It also controls the licensing system. In several provinces, there have been significant reductions in residency and medical school openings. In Quebec, there are restrictions on the number of physicians on hospital medical staffs. Some provinces have placed restrictions on where new physicians may open practices, or on the amount of reimbursement when physicians choose to settle in areas judged to be over-doctored.

No such parallel authority exists in this country. While Congress or state legislatures pass laws, it is up to the administrative branch to implement those laws. No clear focus of responsibility or accountability exists for performance of existing programs, let alone a program as complex as the a single payer system envisioned in current proposals.

Portability of Benefits and Reimbursement. In many areas of Canada, there has been a trend toward regionalization of governmental services-education, police, fire and transportation, to name a few. Canada has many urban areas, but none cross provincial boundaries with the exception of the area of Ottawa, Ontario and Hull, Quebec.

Compare this to the United States. The urban area of Washington, DC crosses political borders of three states. The New York metropolitan area encompasses three states. Some would contend that the area from Boston to Washington is a single urban area. There is significant interstate use of health services in these and many other areas.

Single payer systems tied to state boundaries are politically feasible but may not adequately address issues of regionalization and specialization across state boundaries. Portability of benefits and reimbursement become important issues to contend with. What happens to a person living in Virginia and working in the District? Or someone living in Moline, Illinois who needs special services available only across the river in Davenport, Iowa? Should the New Jersey government be allowed to restrict hospital investment as a cost control measure and encourage people to go to New York for treatment? Will Massachusetts physicians and hospitals be required to accept New Hampshire rates as payment in full? These problems will exist.

Canadians don't typically leave their province for health care. When they do their provincial plan is supposed to be portable, meaning it is obligated under law to pay for services in other provinces. While generally true, this Federal law is not enforced. A resident of Quebec treated outside of Quebec for routine or emergency care, is reimbursed at Quebec rates. Quebec rates are 30–40 percent below those of other provinces. The patient is responsible for the difference.

Reimbursement problems, like that noted above for Canada, are an indication that private insurers do not have a monopoly on such problems. Moreover, government insurers are no more benevolent than private ones. To cite an example, in the late 1970's a man from Montreal, while traveling overseas, suffered a heart attack. He was treated and returned to health. He paid his bill and submitted it to the Regie d'Assurance Maladie, the Quebec government medical services insurance plan. The bill was for the equivalent of $10,000 in the currency of the foreign country. Between the time of his return, and the time that the Regie reviewed the bill the local currency was devalued by 40 percent. The Regie insisted on repaying the man in the local currency, at the devalued level, not in Canadian dollars at the rate of exchange which was used to settle the bill in question. This resulted in a significant out-of-pocket expense for him.

PATIENT EXPECTATIONS AND LIABILITY

An example from Japan will illustrate yet another concern about drawing from other countries without understanding the context within which the health system operates. In May 1989, the Chicago Tribune reported on a lawsuit filed by a patient's family in Japan against the patient's physician. The woman in question was diagnosed with gall bladder and liver cancer. Her physician told her that she had gallstones.

The woman died. Her family sued the physician on the grounds that had she known that she had cancer, she would have agreed to surgery.

The Court ruled that the physician had no obligation to fully disclose information which he or she feels may be harmful to the patient. The article went on to say that in Japan, cancer is considered to be almost always fatal, and physicians do not tell their patients about the presence of the disease as it will destroy their will to live.

Consider the implications of that decision within an American context. We have ever-increasing expectations of treatment and cure ("the magic bullet"), along with a growing insistence on informed consent and information on the range of treatment choices. Armed with a diagnosis, a patient can go to any number of physicians in multiple specialties looking for "the cure" for their problems.

Physicians in this country are armed with a growing number of medical, surgical and pharmaceutical treatments available to combat and cure disease. Combing this with fears of malpractice litigation would create an increased volume of medical services provided at tremendous cost to the system. This example demonstrates the cultural subtleties about health care in another country and the potential folly of the United States adopting a foreign system whose success depends on certain cultural assumptions.

Returning to Canada, malpractice cases are heard by judges, not juries. In addition, cases are not taken on a contingency basis and a losing plaintiff must pay the court costs of the defendant. Lawyers are discouraged from taking cases other than those they are likely to win.

CITIZEN EXPECTATIONS OF GOVERNMENT

People in other countries look to their governments for a different range of services and functions than do Americans. In Canada, there are crown corporations—private companies owned by government. They exist to fulfill a government goal in addition to producing a product. These include broadcasting, transportation, and utilities. These corporations are often in competition with privately-owned companies. Government has owned aircraft manufacturers, steel mills, and other businesses seen as vital to the economic health of a region or particular industrial sector.

In Europe, one can look at the development of Airbus and the Concorde as another model. In France, banks owned by the government play a major role in owning industrial companies in France and other European countries.

These models of government participation in the economy have been an anathema to most Americans. It may also explain why government involvement in health care in other countries is easily accepted.

Putting aside the cost and technical details of a single payer health system (and these are not insignificant details), the essential question is how much government involvement do Americans want in the health care they receive. The polls, focus groups and media stories produce very mixed messages, which are not sufficient on which to make a major change to the delivery and financing of health care at this point. A Flint, Michigan man recently participating in a focus group on national health insurance, indicated he liked the idea of national health insurance, but didn't want the government involved.

Meanwhile, we can learn from states, like Vermont, Minnesota, Florida, Connecticut and others which have enacted legislation to expand access and improve cost control. These models may provide some valuable lessons for policymakers in developing federal health care reform legislation.

CONCLUSIONS AND RECOMMENDATIONS

Adopting the model of a government-administered health care system in the United States makes certain assumptions about this country. Just because other industrialized nations, who appear similar to us, have successfully used this model, it may not necessarily work here. Differences between us and these nations are enormous, ranging from the differing roles of government in the economy and in day-to-day life, expectations citizens have of government, different forms of government (parliamentary government in Canada, for example), unique judicial and cultural factors and consumer expectations of medical care.

The national health insurance proposals developed by Senators Wellstone, Kerry and Daschle make a useful contribution to the policy debate. These proposals do not, however, take into consideration the potential impact of radically restructuring our health care system—for example, the complexity of geographical boundaries and what this means for reimbursement and service delivery.

While the debate intensifies on broad comprehensive reform, some 35 million persons continue to lack health care coverage and spending continues to consume an ever increasing proportion of GNP (now at 14 percent). Yet there is consensus on certain incremental market reforms like those contained in S. 1872. To begin addressing reform for the short term, we urge the Congress to pass this legislation, many provisions of which are contained in the President's and in other Republican and Democratic proposals. Further, we urge the committee to closely look at the experiences of state reform efforts and their implications for national legislation.

For its part, NAM is working with its members and the Congress in support of proposals which balance expanding access with concerns for controlling cost and improving the quality of care delivered. We are conducting a survey of our members on health care reform proposals and on individual company costs. It will update our 1989 survey on corporate costs and provide insight into employer views on various approaches for long term reform. Results will be shared with the Committee when they become available later this summer. In the meantime, we offer the following recommendations on reform as articulated by the NAM Beard of Directors on October 19, 1991:

1. The NAM supports development of a national pluralistic health policy through continuation of a public private system of health care delivery and financing, but recognizes major reforms are necessary.
2. Everyone should have access to appropriate and necessary health care. Access to care must be coordinated with respect to cost and quality concerns.
3. Each person should be responsible for obtaining either private or public health care coverage. NAM opposes mandating employers to provide health care benefits. A critical objective should be to eliminate cost-shifting to the private sector, and within the private sector from employers who do not provide benefits to those who do.
4. Health care spending should be brought in line with our nation's resources and reasonable expectations for improvement in health status.
5. Access to health care is a concern and responsibility for all of society and thus, in both the private and public sectors any financing mechanism should not disproportionately impact any one segment of the economy.
6. Providers should continuously improve the value of health care by delivering quality for health care dollars expended, supporting outcomes research and practice guidelines, making data available to assist purchasing decisions and actively participating in managed systems of care; purchasers must work in tandem with providers to achieve this quality-based system.
7. Medicare and Medicaid and other publicly-supported health programs should have adequate budgets, pay providers properly and fairly to eliminate cost-shifting to the private sector, and adopt efficient cost management and quality goals that emphasize managed care.
8. Medicare should continue to be the primary payer for the elderly and disabled.
9. Improve the legal environment for more effective and efficient health care delivery by enacting federal tort reform to help reduce defensive medicine costs and improve access, providing protection for sponsors of employer health plans, amending laws and eliminating barriers to the use of managed care and group purchasing of health coverage and services.
10. All parties—purchasers/employers, providers, federal and state governments, insurers, labor and consumers—must work together to solve the critical problem of access to care, which cannot be solved without concurrently addressing problems of cost and quality.

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

I hope everyone appreciates how far we have come. It was not long ago that health care reform was not a major issue, whatsoever—not in Congress, not in the media, not in the elections.

When I became Chairman of the Pepper Commission, most people thought we were embarking on a useless exercise. I was warned away from taking on the job. Health care is nothing but trouble, I was told—the issues are too complex, you'll have to talk about taxes, the interest groups will never budge, it's not an issue with voters. It's a thankless task.

I took the job anyway, and I have not regretted it for one minute. I have literally crossed the country to talk about the changes we need in our health care system. I have seen and learned a lot.

In this time, I have seen tremendous progress in moving the issue of health care forward.

We're not here today for a non-stop hand-wringing session over the problem. It's time for a dead-serious discussion of the choices we face to solve the problem.

In 1990, when the Pepper Commission released its plan for health reform, it was declared dead on arrival. But in the last year, detailed reform plans—with specifics, with price-tags, and with some of the trade-offs involved—have been laid down. You'll hear them discussed today. They come from both sides of the aisle. We'll have the opportunity to compare HealthAmerica to Senator Packwood's employer man-

date proposal. We'll hear from a major coalition with business participation and from several key physician groups.

I think we have a real chance to enact *comprehensive* health care reform. True opportunity for the bold changes we need to make is lurking.

The explosion in health care costs, plus the recession, has struck fear in the hearts of the middle class. The average yearly costs of health care for an American family has gone from about $1800 in 1980, to $4300 last year.

That same cost explosion is making it impossible for businesses and industries to both provide health insurance and remain competitive.

And now, the explosion in *federal* health care costs, in Medicare and Medicaid, is becoming the driving force behind our budget deficit—the four or five trillion dollar debt that our children will ultimately inherit.

And there are signals—from the polls, from the primary elections, and from any town meeting that you walk into these days—that we need to solve the health care crisis. To break the gridlock that stands in the way.

The American people are demanding specific answers to their specific problems. And if they keep doing that, and make the November elections a referendum on results—instead of rewarding irrelevant symbols and posturing—we have a real shot at fixing our health care system so it works the way it should.

In my book, every candidate and both parties should be graded on whether they are willing to meet the two real tests of health reform—universal access to health care and meaningful cost containment.

When I put my ear to the ground, the public says they want leadership. They recognize that the federal government has to step in and take some control over the system. They think there's too much money being made off of health care: by the insurance industry, the drug companies, and a lot of the hospitals and doctors.

The pressure from the American people is to control costs. That's the way, they believe, we can expand access. They want a country where we can say all Americans can have quality, affordable health care.

I remain convinced that the approach recommended by the Pepper Commission in 1990 is the most effective, practical way to meet these tests—and to radically change our health care system.

It's the foundation of the HealthAmerica bill that leading Senate Democrats have come together to support, and to push forward.

Our bill lays out—step by step—a detailed program for controlling cost and guaranteeing affordable, quality coverage for every man, woman, and child in America.

Its basis is cooperation. Between employers, physicians, hospitals, consumers, insurers, and others—pulling together to save our system. Give and get, we say.

All employers would be required to do what most do already. They have a choice. Provide basic health coverage to their employees and dependents—or contribute a reasonable amount to support a new, decent public program that will replace the indecent Medicaid.

Play or pay. In return, companies now covering their workers won't have to keep paying the costs that get shifted onto their books from the uninsured. In return, they can count on an insurance market where prices won't keep spiraling out of control. If they are small businesses, we address their concerns with tax credits and subsidies to get started.

Our plan forces insurance companies to stop refusing coverage to the sick and the elderly. Redlining and cherry picking—refusing to write policies for certain areas or industries—would come to a dead halt.

We say that it's time for tough cost containment. We propose an independent Federal Health Expenditure Board. Private citizens, not government bureaucrats, would mediate negotiations between insurers, consumers and providers. Fees and spending limits would then be set—the way the Federal Reserve Board sets discount rates and monetary targets—to help draw order out the jungle of fees and rates that plague health care billing.

This is a plan based on sharing the burden—but for shared benefits. It demands cooperation from business, insurers, doctors, and hospitals. It offers a rational, workable system that won't bankrupt the country—but will save lives and dollars being squandered.

Listen carefully to those that testify today to make sure that their proposals meet the same two key tests. Don't be mislead by scare tactics that millions of people will lose jobs, or that everyone will be forced into a public program and will have to wait for care. We'll never allow that to happen. And if a plan won't assure coverage and won't control costs, it's not satisfactory.

The Majority Leader of the Senate, George Mitchell, is personally spearheading a drive to bring Democrats together around a single comprehensive plan. And it doesn't stop there. With the support of Senators Mitchell and Dole, I've agreed to

co-chair a bipartisan effort to promote meaningful health reform. Our nation is crying out for change and we must seize the moment.

Groups representing business, consumers, and providers are stepping up the pressure. And in turn, the pressure is heating up on them to bring something to the table.

And efforts are building and building to make health care one of *the* issues in the coming elections—in every state, at every level.

We have come a long way on this issue. And I, for one, have no intention of letting this opportunity go by. With your help, I know we can rebuild our health care system.

PREPARED STATEMENT OF J. PATRICK ROONEY

MEDICAL CARE SAVINGS ACCOUNTS

Mr. Chairman, Members of the Senate Finance Committee, my name is Pat Rooney. I am the Chairman of Golden Rule Insurance Company of Lawrenceville, Illinois. I am pleased to be here today to discuss with you my support for the concept of Medical Care Savings Accounts. I strongly believe such accounts can be an important component in addressing the problem of runaway health care costs.

Last week when I was in Phoenix, I was going to buy my wife a present. The first thing I asked was the price. Why? Because I was using my own money. Likewise, when Americans buy a car, or a refrigerator or a stereo, they compare price and service and value.

In most cases, Americans do not ask the same questions when it comes to medical services. Last month there was a letter to the editor of the New York Times that illustrates this problem. The writer of the letter complained to Blue Cross about the insurance carrier's inability to control what the hospital had charged. The author's wife had a tiny glass shard removed from her finger tip. The minor surgery cost more than $2000. The author called in to the insurance company about a part of the bill and was told that since he didn't suffer any cost, why should he care what it cost? By the way, the family doctor told them he could have done the surgery in the office for $100.

The reason I tell you these two stories is to show you how consumer behavior changes when we are spending our own money or someone else's.

In April of 1991, the Congressional Budget Office issued a report entitled: Rising Health Care Costs. The report said, the normal discipline of the marketplace doesn't work regarding health care because as soon as we reach the deductible, we are spending someone else's money.

To restore the normal discipline of the marketplace, we must get the self-interest of the consumer involved again when purchasing health care.

And, Medical Care Savings Accounts would do that.

Right now, employer-purchased health coverage costs on average $4,500 a year for a family.

The employee may be paying some of that, but it is all going to the insurance company. In exchange, the family gets a health insurance policy with a low dollar deductible, usually $100 or $250. But once the low deductible is met, the insurance pays all or virtually all of the bills.

With Medical Care Savings Accounts, we are taking the same amount of money that is currently being spent and just redistributing it.

Instead of sending $4,500 a year to the insurance company, the employer would pay out $1,500 for a policy with a $3,000 annual deductible, and then there would be $3,000 left to put in a Medical Care Savings Account for the employee's family. If the employee spent more than that $3,000 on medical care, the insurance policy would protect them to $1 million. But, and this is where the self-interest of the employee comes in, if there was money left at the end of the year, they would keep it and roll it over into a medical IRA. And, each year the process would start over—the employee would get $3,000 in the Medical Care Savings Account, and would be protected by the high deductible catastrophic policy if medical expenses went over $3,000.

If an employee is a wise consumer of medical care and has no catastrophic event that year, the employee will be part of the 90 percent of all insureds who spend less than $3,000 on medical care each year. Just think of the savings formation, something this country desperately needs.

And, look at the savings on the insurance administration. Because people will be paying for the first $3,000 of medical care out of this account, the insurance company doesn't have the contractual obligation to scrutinize every $50 claim that

comes across the desk. As an insurance executive, I can tell you that we are no good at processing the small claims. It costs us too much. With Medical Care Savings Accounts, we would just debit the person's account.

What I have just talked about is the first reason for having Medical Care Savings Accounts: They will bring the self-interest of the consumers to bear on the cost of medical care because the consumers will start asking, "What's this going to cost?"

The savings that would belong to the employees are largely brought about by the immense reduction in the administrative costs in processing the small claims.

The second reason for Medical Care Savings Accounts is that the account is portable—it goes with the employee.

Today a lot of workers fear they might lose their job and then be without insurance. With Medical Care Savings Accounts, if you lose your job, you would have money in the account to pay your former employer your COBRA premiums until you found a new job and got on their insurance. A recent study published by Blue Cross showed that 70 percent of all uninsureds are uninsured for 12 months or less—half are uninsured for four months or less.

Medical Care Savings Accounts can knock a big hole in the uninsured population—without a cost to the US Treasury—by simply creating the fund that will enable employees to stay insured until they get a new job.

The third reason for Medical Care Savings Accounts is that such accounts would eliminate the deductible, which is an immense help for the financially stressed employee.

Under the present insurance system—and under most of the reforms that are being proposed—the financially stressed employee (frequently a single mother) may not have that first $250 deductible to pay for taking a sick child to the doctor in January. With Medical Care Savings Accounts, we have essentially removed the deductible because she would have the money in the account provided by the employer to pay for any medical care she or that sick child needed.

Members of the Finance Committee, the people need your help. We need to change the tax law to permit any money left in a Medical Care Savings Account at the end of the year to roll over into a medical IRA without adverse consequences to an employee. Employers can set up these accounts now, but any money left at the end of the year must be spent by the employee on medical care or it must revert to the employer (the Flexible Spending Account use-it or lose-it rule).

The current tax treatment can often actually add to the problem. It makes people spend more because they don't want "their money" to revert to the employer.

We need to change the incentive. Let the employees have the money and roll it into the IRA. We need to have the employees asking about cost because it's "their money."

LET'S SUMMARIZE

In the present situation—or in most of the proposed legislation—$4,500 a year on average is being paid by the employer to the insurance company to pay for a family's insurance. In some places, it's higher. That's sunk cost. The employee doesn't get any of it back.

If the child has an ear infection in January, your insurance is no help because you haven't yet spent your $250 deductible.

In the year when you have your gall bladder taken out, it costs you the $250 deductible plus a 20 percent copayment on the first $5,000. A total of $1,250 out of your pocket.

With a Medical Care Savings Account, the same $4,500 is spent but only $1,500 goes to the insurance company to purchase a high deductible policy. $3,000 goes to the employee to use for medical care.

If the employee's family spends only $1,000 on medical care, there is $2,000 they can keep.

When the gall bladder surgery happens, the first $3,000 of medical expense comes out of the Medical Care Savings Account. The rest comes from the insurance plan. The employee is fully protected.

In the year where the child has an ear infection in January, the employee has the money to pay for the doctor's visit and prescription. Any funds left in the account at the end of the year are available to rollover into a IRA.

Which would you rather have? I'd rather have the Medical Care Savings Account.

THE DATA—AT THE $3,000 THRESHOLD

Example No. 1: Heartland America, which includes Denver, Peoria, Cincinnati, and Scranton

Example No. 2: Chicago

	Heartland America	Chicago
Percent of insured persons with claims in excess of threshold	6.0%	8.5%
Percent of claim dollars in excess of threshold (i.e., threshold equals a per person deductible)	31.0%	38.0%
Typical employer-purchased group premium for family	$4,500	$6,000
Cost of umbrella policy (threshold $3,000)	$1,500	$2,500
Dollars that could be turned over to employee from which employee could pay low dollar claims for family	$3,000	$3,500

Claims paid by the employee out of pocket have no administrative overhead for claim administration.

Claim distribution analysis is based on work done by Tillinghast.

Assumptions: Based on employer group experience with cost containment provisions (i.e., precertification of specified services and inpatient stays, concurrent review, and large case management). The benefit package included preventive services.

The New York Times

WEDNESDAY, MAY 6, 1992

Health Insurers Pay Bizarre Hospital Charges

To the Editor:

Blue Cross and Blue Shield can avoid insolvency by other means than a rate increase: it can reduce expenditures by taking a closer look at each hospital bill before settling the claim.

Each item of a bill is paid by Blue Cross and Blue Shield according to a standardized schedule of prices, but no question is raised about the necessity of the services charged.

A patient handing a signed insurance claim form to a hospital admitting nurse is handing over a blank check. The hospital fills in the amount. Few patients, since the money is not theirs, examine their copy of the bill. I did it once.

My wife had a microscopic glass shard in her finger tip of which she was hardly aware. Once, visiting a friend in a hospital, she mentioned it to the friend's surgeon, who told her by all means to come to the hospital and have the shard removed.

At the appointed hour, my wife was surprised to find herself in the presence of two surgical residents in addition to the attending surgeon and two nurses. The cost of the operation, which required an incision less than a quarter-inch in the finger tip under local anesthesia, was $2,200, excluding the physician's fee. In addition, $200 was charged for the removal of stitches. Not a word on the bill described the nature of the operation.

My family doctor was amused by the figures. He could have performed the identical "operation" in his office, he said, at a cost of $100.

I called Blue Cross and Blue Shield and discussed the matter with a supervisor. I was disturbed by the $600 charge for the recovery room, in which my wife spent an impatient quarter-hour. The supervisor remained polite as I explained, but I could detect anger in her voice. The gist of her position was that, since I did not incur any costs, the matter was not my concern.

When damage to a building or an automobile is reported to an insurance company, it dispatches an investigator to appraise the damage before paying for the repairs. If it did not, it would soon be out of business. Hospitals should not be exempt from a similar policy.

Nothing prevents Blue Cross and Blue Shield from mailing a copy of the hospital bill to the patient with a request to check the nature of the operation and the length of stay in the hospital. A visit from a Blue Cross and Blue Shield representative could be helpful. Hospitals would become more careful if their veracity was questioned.

JACQUES LIWER

Hollis wood, Queens, April 16, 1992

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PREPARED STATEMENT OF CARL SCHRAMM

I am Carl Schramm, President of the Health Insurance Association of America (HIAA). HIAA is a trade association of over 275 private health insurance companies that provide health insurance to over 95 million Americans. Over the past few years, HIAA has dedicated significant time and effort to analyzing health access and cost problems in order to develop practical solutions. We have shared our views at numerous Congressional forums, including testimony before this Committee. I am pleased to appear before you again today as the Committee continues its work on reforming the health care system in the United States.

In discussing universal coverage and single-payer systems, the Canadian model has received the most attention and analysis. But rather than begin my testimony as an American commenting on the Canadian health care system, Mr. Chairman, I would like to offer the words of Dr. Gur S. Singh, president of the British Columbia Medical Association from February of this year.

> "Canadians should be thankful to the American system for the vast improvements in health care technology that have occurred in the past couple of decades. Canada used to be the leader in medical research and development—now we rely heavily on other countries to make up for our defencies. What would happen if every other country in the world followed took our lead? Would there be further improvements in health care?
>
> Instead of condemning the American system and urging Americans to adopt the Canadian health care system, Canadians should be praying that President Bush's proposal to guarantee uninsured Americans access to quality health care is accepted and that the American system remains otherwise unchanged. Such changes will allow the American system to continue to provide the necessary safety valve to an overly restrictive Canadian system, which will only get worse as further bureaucratic controls are adopted.
>
> Canadian politicians would love voters to believe that all is well in lotus land, that our health care system remains the finest in the world, that every Canadian has unfettered access to all medical services, and that the American health system is evil. The reality is that none of these beliefs holds true."

Mr. Chairman, in the time remaining, I can only add detail to Dr. Singh's remarks.

A CANADIAN STYLE SYSTEM

Several of the more than fifty proposals now before Congress call for an act of desperation by the United States: The adoption of Canadian-style public health insurance. It is characteristic of wisdom not to do desperate things, said Thoreau, and several factors evince why adopting the Canadian system would be injudicious. Claims are made that Canada has controlled health care costs more effectively than the United States since Canada spends only 9 percent of its gross national product (GNP) on health care, as compared to over 12 percent of GNP spent in the United States.

- *Despite these claims. Canada has not controlled health care cost escalation*

If trends in health care costs per capita are analyzed, it becomes clear that Canada has fared little better than the United States at controlling cost escalation. Since 1971 (when public universal insurance was implemented in Canada), health care costs per capita have grown at an average rate of 10.7 percent per year in Canada, compared to 10.6 percent per year in the United States. The percent of GNP devoted to health care grew more slowly in Canada than in the United States not because Canada controlled health care spending, but because Canada's economy grew faster than ours. Between 1971 and 1990, Canada's economic output per capita grew 60.5 percent in real terms, compared to only 37.2 percent growth in the United States.

- *Canadians endure long waits for major surgery, and the standard of care is beginning to fall behind current available technologies*

More importantly, Canadians have to put up with the health care consequences of government attempts to control costs. Because there are no charges to patients, access to care for "sniffles, sneezes, and splinters" is no problem in Canada, but some patients in need of serious surgery have to wait many months for their operations, due to lack of facilities. Modern diagnostic equipment is also in short supply in some provinces, which leads to long waits for such tests as computerized tomog-

raphy scans and mammograms. Provincial authorities tacitly have admitted that waiting lines for heart surgery are too long, since they agree to pay for Canadians to have surgery in U.S. hospitals.

- *Controlling health care budgets does not eliminate unnecessary care and waste in the health care system*

While arbitrarily restricting access to expensive high-technology procedures, Canada's provincial health plans make no attempt to determine whether care ordered by physicians is really necessary, despite the large volume of evidence (in the U.S. and elsewhere) that a significant proportion of services ordered by physicians are unnecessary, ineffective, or actually counter-indicated. Inappropriate care, which may constitute as much as 25–40 percent of all care rendered according to some estimates, is the real cause of waste and excess expense in the health care system.

- *Canadians are stuck with a "one size fits all" system*

Canadians lack choices—not of specific doctors and hospitals, but of the overall delivery system and the extent of coverage. In the United States, if an employment-based group chooses to reduce its current outlays for insurance premiums and protect themselves only against very major medical bills, for example, they can buy lower-cost insurance.

These choices are not available to Canadian citizens. All must belong to the same system and accept its deficiencies as well as its benefits, unless they choose to be restricted to the very few private hospitals and physicians or to seek care outside the country. Thus, if the government seeks to control costs by restricting the availability of hospital beds or new equipment, citizens who need care must either wait for service or pay privately to go outside the system.

- *The Canadian system would be in worse shape if it did not have the U.S. health care system right next door*

First, as Dr. Singh revealed, Canadians need not spend large sums developing new medical technology—they can wait for the United States to develop it and reap the benefits when it is ready. Second, the United States relieves the pressures that would otherwise build requiring expansion of the Canadian system and additional spending. For example, with few exceptions (e.g., cataract surgery), it is almost impossible for individuals to shorten their waiting periods for surgery within Canada because there are virtually no private hospitals; but Canadians who are willing and able to pay privately to obtain care sooner can come to U.S. hospitals and clinics. If the United States were to adopt the Canadian system, this safety valve for Canadians would no longer exist, nor would there exist one for Americans.

This naturally begs the question of where would those needing treatment in the United States turn? Certainly not to another socialist system like the United Kingdom. About 100,000 have been waiting at least one year and up to three for "elective surgery" such as cataracts operations and hip replacements. If this were to happen in the U.S. on a comparable scale, the entire state of Delaware would be waiting years for medical care to be able to do such "elective" activities as walking and seeing.

- *Administrative Costs*

One of the major rationales national health insurance advocates give for their claim that government-run health insurance would be cheaper than our current system is that administrative costs are lower in government-run systems. Canada and Medicare are the examples usually cited. No doubt there are some administrative functions that become unnecessary under a government run program. But, more often, the functions and costs are still there but are simply ignored under government accounting rules. Private insurers, for example, must set aside contingency reserves against the risk of unexpectedly high medical claims. Government simply hopes for the best and allows the deficit grow larger if initial estimates are too low.

Also frequently ignored is the fact that one of the major "administrative costs" incurred by insurers is the premium tax they pay to state governments, and other taxes and fees, amounting to about 3 percent of total premium. These tax revenues would be lost if a government-run system were to be put in place.

But let's put this administrative cost issue in proper perspective. Clearly, it costs us more to administer our pluralistic health care system than it costs the Canadians to run their unitary system. The issue is not so much what it costs but whether we get something of value in return. For example, in this country you can mail a first class letter for 29 cents, if you want to. But if it absolutely, positively has to get there the next day, many people willingly pay much, much more. I think there

are two main areas where private insurance is out-performing government insurance in this country. First is service and second is the commitment to managing care for cost-effectiveness and quality. It's pretty clear to me that one of the reasons Medicare is so cheap to run is that it provides no customer service. Both patients and providers say that it's impossible to reach Medicare on the phone to deal with a payment problem. I'm sure you get those complaints in your offices every day from irate constituents. In the private market, on the other hand, providing good service is one of the ways insurers compete for business.

More importantly, over the past 10 years, private insurers have invested literally billions of dollars to establish managed care networks because they believe that managed care is the only rational way to make our health care financing system more efficient while preserving high quality care. When experts agree that 25 to perhaps 40 percent of medical services provided yield no significant medical benefit, and in some cases are downright harmful, it is clear that we need to focus administrative resources on making sure that the medical care our insureds receive is appropriate and of good quality.

Government-run systems are notoriously poor at this kind of individual judgment. The PROs and their predecessors have been at best marginally effective; and legal requirements make it impossible, for all practical purposes, for government to develop effective managed care systems based on selection of efficient physicians and hospitals, as private insurers are aggressively undertaking to do. Thus, government health insurance programs in most other countries, such as Canada, typically address cost control by simply limiting physician fees and putting a cap on hospital expenditures without changing the way medical services are rendered. Moreover, Canadians may claim that their system is not "socialized medicine," because providers are not directly employed by the government, but there is little doubt that the allocation of health care resources is centrally planned, just as it would be in a socialist state: In Canada, all major hospital decisions to invest in new technology or services must be approved by the provincial governments.

The consequences of this kind of approach are clear from the Canadian example.: New, high-tech services simply are not adequately available in Canada, and therefore, patients who need them have to wait in line. A recent Harvard School of Public Health study reveals that Canadian doctors "are highly concerned about their ability to get access for their patients to special care and medical technology."

Overall, Canadians wait three times longer than Americans to see specialists and to have elective surgery, according to the 1992 Harvard study.

This "rationing by queue" is the inevitable result of government attempts to control costs by restricting health care budgets while publicly espousing a commitment to universal access. Because anything new represents an additional cost, existing inefficiencies, and leads to obsolescence.

The essence of the American health care system, in the Aristotelean meaning of the word, that quality which is enduring and immutable, is its ability to adapt quickly to changing needs and to develop and rapidly employ new and better ways of treating illness. Such responsiveness is clearly not possible when all major resource allocation decisions are made by government, particularly a government concerned primarily with cost control.

While many issues have been called before Congress, Mr. Chairman, few have received the attention that national health insurance has over the years. Since the late 19th century when Bismarck established a health program for Prussian workers to lessen the appeal of Marxism and Socialism, there have been calls for a similar system in the United States. While the health insurance industry recognizes the need for change and is answering the call, we feel that a move toward the socialist system of Canada would be, in the words of the French politician Boulay de le Meurthe, "worse than a crime, it would be a blunder."

HIAA has put forth a proposal to prevent such a blunder that requires the Federal and State Governments to live up to their responsibility of taking care of the poor and near-poor while we ensure that health insurance coverage is available to all Americans.

Toward this end, the health insurance industry must extend coverage to all individuals within a group and guarantee its "portability." Limits must also be placed on how much a carrier can raise rates for a specific group above and beyond general increases in trend factors. State governments must authorize private not-for-profit reinsurance organizations and risk pools. At the federal level, all insured plans must be exempted from state mandated benefits. The 100 percent tax deduction must be given to all small business entities, including the self-employed. Low income individuals must also be allowed access to primary and preventive health care service packages.

The private sector led by the insurance industry is already moving ahead with major health care initiatives, anti-fraud measures and the streamlining of administrative costs. We are particularly confident that managed care can not only deliver medical treatment of a high quality, but reduce costs by as much as 50 percent as companies have happily reported. One-third of the country's population is presently enrolled in some type ofmanaged care program.

Mr. Chairman, opportunity is transient as Goethe once observed. We now have a unique opportunity to reform health care in the United States with the support of the Administration, Congress, the industry, and most importantly, the American people. But efforts to force the United States down a socialistic path to a Canadian system will squander the moment. And as an Arabic aphorism reminds us, "Neglected, opportunity rarely returns."

At the beginning of the century, in the early years of the automobile industry, fir. Chairman, Americans could only buy one type car from one company that was controlled by one man. But Henry Ford would sell the Model–T in any color the buyer wanted, so long as it was black. Such will be the "service and selection" Americans will experience if a Canadian-type national health insurance program replaces the present system in the U.S.

Americans deserve the best medical care, not a system that is merely fair and uniform. Millions of citizens in the former Soviet Union queued to buy the Volga, the state-produced, standard-issue car that was cheaper than anything made in the U.S.: Most are still waiting. Does the U.S. want this to be the model for the health care system?

PREPARED STATEMENT OF DANIEL W. SHEA

Mr. Chairman, members of the Committee, I am Daniel Shea, M.D., President of the American Academy of Pediatrics. I am here today representing 43,000 physician members who are dedicated to the health, safety and well-being of infants, children, adolescents and young adults. Thank you for inviting me to address the important issue of children's access to health care.

The American Academy of Pediatrics commends the Chairman and members of this Committee for their legislative efforts to bring about health care reform. Legislation such as S. 1227, the HealthAmerica Act, introduced by Senate Majority Leader George Mitchell, and S. 2114, the Comprehensive Health Insurance Plan, introduced by Senator Robert Packwood, have helped to focus the issue of expanding employment-based health insurance coverage. While there are a variety of proposals, we are all agreed that health care reform must be addressed.

My message today is simple and direct. The American Academy of Pediatrics (AAP) believes all children must be guaranteed financial access to necessary, appropriate and effective health care services.

The needs of children must be addressed up front in the health care reform debate, with an appropriate benefit package spelled out and guaranteed. Children's benefits must be uniform, regardless of whether they receive them through a public plan or the private sector. Too often it is assumed that if we provide basic benefits for everyone, then children will be provided for. The fact is, children are different from adults and have unique health care needs. A specific benefit package for children has been defined by the Academy and should be guaranteed up front, or they will fall to the end of the line, with the very real possibility that their needs would be inadequately addressed or even ignored.

To ensure that the needs of children are addressed in the health care reform debate, the AAP has developed a proposal to address access to health care for children and pregnant women. This proposal, entitled "Children First," provides for financial access to health care for all children through age 21 and for all pregnant women.

Congressman Robert T. Matsui (D–CA), turned the Academy's "Children First" proposal into legislative action by introducing H.R. 3393, "The Children and Pregnant Women Health Insurance Act." H.R. 3393 is a play or pay plan which establishes health care as a right for all children and pregnant women and could serve as a first step for other legislative proposals that could cover the entire population. We expect that similar legislation will be introduced in the Senate shortly.

We believe that H.R. 3393 serves as the benchmark to evaluate all other health care access proposals from both the House and Senate, to ensure that children and pregnant women are first, not last on the priority list, to receive the health care they need.

THE CASE FOR CHILDREN FIRST

The Academy believes all United States citizens deserve proper medical care, but we believe that, as we move towards universal health care reform, the first step should be health care coverage for children and pregnant women. Our children simply cannot afford the time it may take to debate and enact a universal health care reform bill. Children's access to health care has been neglected by our society. As this Committee recognizes, we cannot afford to ignore this crisis any longer. The time has come for the United States to become a nation that makes the health and well-being of its children its highest priority.

The fact is, children, our most vulnerable population, are 29 percent of the population, but they represent 36 percent of the uninsured. Approximately 12.2 million children have no health insurance, sixty-five percent of whom live in families whose income is above the federal poverty line. Add to these another 10 million children who are uninsured during some part of each year. Additional tens of millions more children are underinsured. These uninsured are without adequate benefits for necessary treatment services and for even the most basic care needed to prevent unnecessary disease and death. Still others are "uninsurable" because of preexisting chronic or recurring conditions. Families with children who have complex health problems should not be further burdened with often impossible decisions about how to pay for the critical and often multiple health services needed.

PROBLEMS WITH INSURANCE

Unfortunately, even plans that do cover dependents often fail to meet the health care needs of children, since their needs are not the same as adults. Most child health services are provided as outpatient services, and these services are often not covered by health insurance. Private health insurance plans most often have an array of benefits designed to cover an adult pattern of utilization (inpatient care and high-cost procedures), but they do not address children's needs.

VALUE OF PREVENTIVE CARE

Not only are uninsured children unable to receive medical attention when they are sick, but they also fail to receive preventive care. The uninsured, concerned about the costs involved, too often wait until an illness is advanced before seeking care. Without preventive care, these children are much more susceptible to communicable and other illness, and once sick, have no insurance to pay for their care.

Preventive care, the hallmark of pediatric practice, is poorly covered if at all, despite the economic payback and medical efficacy of childhood immunizations, prenatal counseling and care, and screening for anomalies that may prevent or lessen lifetime disability when detected early. The Academy believes that preventive care is critical to any proposal designed to provide a healthier future for our children.

There are abundant data that show that lack of preventive care leads to serious health consequences. Uninsured children tend to experience delays in care leading to more expensive, and less effective treatment with poor outcomes. Tragically, outbreaks of preventable diseases are increasing. Between 1983 and 1990, the incidence of measles increased nearly 1800 percent despite the fact that this potentially deadly disease is easily prevented by immunization. The goal of the U.S. Public Health Service was to reduce the annual number of measles cases to 500 by 1990. Instead, the nation averaged 500 cases and more than one death per week that year.

We need health care reform that specifically addresses the unique health care needs of children so that they no longer have to suffer unnecessarily. Vaccines have been highly effective in preventing infectious diseases. Along with the obvious health benefits, vaccines are cost-effective as well. For every $1 spent on immunizations, we save an estimated $10 in future health care costs.

Prenatal care, perhaps the best investment society can make in terms of immediate and long-term savings, is frequently excluded from private insurance. For every $1 spent on quality prenatal care, more than $3 can be saved by reducing the number of low birthweight babies. Delay or absence of prenatal care may lead to unnecessarily complicated pregnancies.

THE FIRST STEP

The health care reform movement has produced many proposals and the search for consensus is now underway. The AAP strongly believes that such consensus can and must, begin with the health care of our children and pregnant women. The AAP also believes that Congressman Robert Matsui's legislation, H.R. 3393, modeled after the Academy's "Children First" proposal, should serve as the first step of whatever health care reform package Congress decides to adopt.

H.R. 3393 includes the following Academy principles:

- *Guaranteed financial access to health care for all children (through age 21) and all pregnant women*

All children through age 21 and all pregnant women will be guaranteed financial access to necessary, appropriate and effective health care services, regardless of family income, employment status, ethnic origin, geographical location or health status. Beneficiaries would be provided with private health insurance with comprehensive benefits either through employers or a state administered fund.

Similar to other play or pay plans, we require employers to provide qualified private insurance to employee's dependents who are under age 22 or pregnant, with the employee paying no more than 20 percent of their insurance premium. If the employer chooses to provide insurance through the State Administered Insurance Fund, they would be required to pay a 3.2 percent payroll tax (up to the Medicare wage base) and the employee would pay a 1 percent payroll tax (up to the Medicare wage base).

The Academy supports the play or pay approach as an attainable mechanism, since most Americans already receive their health insurance through their own or a family member's employment. By causing minimal disruption to the current system, play or pay offers a pragmatic approach which can be implemented now. Currently health care costs are inequitably distributed among businesses since some provide health insurance while others do not. H.R. 3393 will alleviate this cost shifting by involving all businesses in the provision of health insurance while making health insurance more affordable for small businesses through group participation and community rating.

- *A basic, comprehensive benefit package*

Similar to Medicaid's mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the Academy calls for a mandated basic, comprehensive benefit package for both public and private plans. Benefits required include:

(1) *Preventive Health Care:* Preventive health office visits, immunizations, and laboratory tests; prenatal care; newborn infant care; child abuse assessment; and preventive dental care for children. The schedules of preventive care for children and prenatal care for pregnant women are established standards of care developed by the AAP and the American College of Obstetricians and Gynecologists. There are no deductibles or coinsurance applied for preventive services.

(2) *Primary Major Medical Services:* Inpatient and outpatient hospital services; physician services; professional services of nurse midwives, nurse practitioners, and other health professionals; diagnostic tests; durable medical equipment; acute dental care for children; prescription drugs, and medically recommended nutritional supplements.

(3) *Extended Medical Services:* Mental illness and substance abuse treatment; speech, occupational, and physical therapy services; hospice care; respite care; and short-term skilled nursing facility services.

- *A one-class system of medical care to replace the pregnant women's and children's portion of Medicaid*

The American Academy of Pediatrics believes that regardless of initial safeguards, any public Plan designed primarily for low-income people would eventually degenerate into a second class system of care as the result of inevitable political and economic pressures.

Medicaid, itself, has exaggerated a two-tiered system of care in which eligibility, benefits, and reimbursement limited by lack of funds, vary from state to state.

Medicaid still retains a welfare stigma and must be applied for with a means-test administered by the public aid system. Despite recent Medicaid expansions, 28 percent of children (3.5 million) in families below the poverty line remain uninsured. Medicaid, although needed in the short run, is not viewed as the long term solution we need.

H.R. 3393 addresses the Medicaid problem by establishing a one-tier system of medical care by replacing, with private insurance, the portion of the Medicaid program currently serving children and pregnant women, and by requiring uniform, comprehensive benefits.

- *Pre-existing condition clauses eliminated*

Uninsurability due to preexisting medical conditions would be eliminated. These clauses represent a serious and unnecessary barrier to care for uninsured children.

COST CONTAINMENT

While H.R. 3393 does contain innovative cost containment measures, it's important to understand that children are not a significant factor in our increasing health budget. In fact, persons under age 19 are 29 percent of the population but account for only 11% of all health expenditures. The average annual medical care spending for a young person is less than ½ of that for an adult under age 65 and ⅐ for one over 65.

H.R. 3393 achieves savings through the promotion of preventive care, cost-sharing (premiums, deductibles and coinsurance) and care-coordination for medically complex children. The legislation establishes a resource based relative value scale for pediatric and obstetric services. It requires the Secretary of Health and Human Services (HHS) to establish a National Advisory Committee, composed of pediatricians, family physicians, obstetricians, and experts on maternal and child health. The National Advisory Committee will advise the Secretary of HHS on appropriate payment amounts (including the conversion factor) and factors that influence the adequacy of health funding for children and pregnant women (such as quality of care and distribution of services).

CONCLUSION

The present status of US children's health care demands that their needs be addressed first, rather than last, in the coming debate. Their benefit package must be appropriate, as opposed to "bare-bones" and specific to their needs, not left "to be spelled-out" later.

We believe "Children First" provides an attainable first step towards universal access to health care. Most important, it spells out in detail, and guarantees, health benefits children require. It provides access to health care while minimizing disruptions in existing health care financing and delivery systems. We can address our children's needs now while the debate continues over universal health care reform.

The AAP urges prompt Congressional action to ensure that children have access to the health care they are entitled to. We look forward to working with you as Congress considers this issue.

Thank you.

PREPARED STATEMENT OF JOHN SHEILS

My name is John Sheils. I am a Vice President with Lewin-ICF, a Washington-based consulting firm, specializing in health care financing issues. I have performed financial analyses of various health care reform proposals for several public and private organizations including: the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission); the Congressional Research Service; the Advisory Council on Social Security; several state commissions; the American Hospital Association; and other private organizations. I have been asked to summarize some of our estimates of the cost implications of the Health American Act as reported by the Senate Committee on Labor and Health.

Our analyses of S. 1227 have addressed several issues, the results of which I summarize here today. My testimony is presented in three parts. These are:

- Part 1: Savings in National Health Spending under the Health American Act;
- Part 2: Public plan Enrollment Under Pay or Play;
- Part 3: The impact of the Health American Act on Employment.

Our findings are presented below.

PART ONE: SAVINGS IN NATIONAL HEALTH SPENDING UNDER THE HEALTH AMERICAN ACT

The 1980s were a paradox of dramatic increases in health spending and diminished access to care. Health spending as a percentage of gross national product grew from 9.1 percent in 1980 to about 12.3 percent by 1990 (Figure 1). Despite the dramatic growth in the share of our national wealth devoted to health care, the number of persons without health insurance increased from 24.5 million in 1980 to over 33.3 million by 1990. Rising costs have made health insurance less affordable, which has contributed to reductions in insurance coverage, increased uncompensated care costs, and increased the strain on state and local indigent care programs. Cost containment will be an essential element of any program to expand insurance coverage and could prove vital in maintaining even the existing level of access.

The importance of containing the growth in health spending is evident in current projections of health spending for the next decade. The Health Care Financing Ad-

ministration (HCFA) projects that per capita spending on health care will increase at an annual rate of 8.2 percent per year through 2000. This is about twice the projected rate of inflation. In 1992 health care costs are estimated to be about $809 billion. By 2000, health spending is projected to more than double. This represents a real increase (inflation adjusted) in per capita health spending over this period of about 37 percent.

The Health America Act would expand access to health insurance coverage while implementing a program of system-wide cost containment. The program would lead to an increase in health services utilization as insurance is extended to previously uninsured persons. However, these increases in costs are likely to be more than offset by savings resulting from the program of cost containment proposed under the bill, which includes the establishment of a Federal Health Expenditures Board charged with establishing National Health Spending goals.

We estimate that the Health American Act as reported by the Senate Labor and Health Committee version will result in a net reduction in health spending of between $83.9 billion and $215.3 billion over the 1993 through 1997 period. As explained below, this savings estimate applies only to the Labor and Health Committee version of the Bill, which empowers the newly created Federal Expenditures Board to impose provider reimbursement rates which are consistent with National Health Spending goals. This differs from the earlier version on S. 1227 which substantially limits the Board's ability to set reimbursement levels. We estimate that the impact of the earlier version of S. 1227 would be a net reduction in Health Spending of about $46 billion over five years compared with five year savings of up to $215 billion under the Labor and Health Committee Bill.

Our estimates of the potential impact of the bill on national health spending are discussed below.

A. Utilization Increase for Previously Uninsured Persons

The Health America Plan would extend coverage to all Americans by 1997. This will be done by: (1) requiring employers to either provide insurance or cover their workers under a public program by paying a payroll tax; and (2) covering non-workers under a public program. Expansions in coverage will be phased-in between 1993 and 1997 as follows:

- Beginning in 1993, the employer coverage provisions of the Bill will apply to firms with 100 or more workers. Coverage of pregnant women and children under the public plan will also begin in this year.
- In 1996, the employer coverage provisions will be extended to all firms with 25 or more employees.
- The employer coverage provisions will apply to all firms beginning in 1997. Coverage of non-working adults under the public plan will also begin in this year.

Utilization of health services by previously uninsured persons is expected to increase as these individuals become insured. Utilization of health services by previously uninsured persons is assumed to adjust to the levels reported by insured persons with similar age, sex, income and health status characteristics.

The cost of increased utilization for newly insured persons would be $7.2 billion in 1993 growing to $14.7 billion by 1997 as the expansion in coverage is fully phased-in. The total increase in utilization for newly insured persons would be $52.1 billion during the 1993 through 1997 period.

B. Cost Containment

The Health America Plan establishes a Federal Health Expenditures Board which is responsible for setting aggregate national health spending "goals" for future years. Separate expenditure goals will be set for: hospital services; physician services; laboratory services; pharmaceutical products; durable medical equipment; and other health sectors (other than long-term care) deemed appropriate by the board. While the Bill provides guidance on how these expenditure goals are to be determine, it does not specify the specific criteria to be used (i.e., per-capita spending growth rates, spending as a percent of GNP, etc.).

The Bill requires that the Board negotiate with provider representatives to establish reimbursement levels and methods of payment consistent with meeting spending goals for hospitals and physicians. If the Board and provider representatives fail to reach agreement, the Board has the authority to unilaterally impose reimbursement levels and methods for hospital and physician care which are consistent with these spending goals. The Board is required to negotiate spending controls with hospitals and physicians only. However, the Board has the option of requiring negotiations with other health sectors as well.

The Health America Plan includes several cost containment initiatives that will contribute to savings under the Bill. These include:

- **Small Group Insurance Market Reforms** to eliminate underwriting practices and reduce other administrative costs.
- **Outcomes Research** designed to develop medical practice parameters that will eliminate unnecessary and ineffective treatments.
- **Technology Assessment** to determine the appropriate use and reimbursement levels for new technologies.
- **Promote Competition** by requiring providers to publish rates.
- **Expand Managed Care** by pre-empting state legislative barriers, assuring small business access to managed care plans, and providing managed care alternatives under public health programs.
- **Pre-empt State Mandated Benefits** to permit insurers to develop low-cost insurance products.
- **Reduce Administrative** costs by consolidating administration for small employers through an insurance consortia, and creating quality improvement agencies to coordinate utilization review.

We estimate that these initiatives will result in savings of $67.7 billion over the 1993 through 1997 even in the absence of establishing a federal expenditures board (Table 1). These savings would be supplemented by additional savings through provider rate negotiations under the federal expenditures board program as discussed below. (The methods used to develop these estimates are discussed in Appendix A).

C. The Impact of Expenditure Goals on Health Spending

The Health America Act would establish a Federal Health Expenditures Board charged with setting National Health Spending goals. The Board is also charged with negotiating provider reimbursement rates with representatives of the health care provider community. In the version of the Health America Act reported by the Senate Labor and Health Committee, these negotiations are' binding, thus enhancing the Board's ability to set rates which are consistent with National Health Spending goals. This differs from the earlier version of S. 1227 in which the Board-negotiations with providers were non-binding.

In this analysis, we estimated this impact of the Federal Expenditures Board as estimated under the Senate Labor and Health Committee version of the Bill. The impact that the Federal Expenditures Board will have on health spending is difficult to predict. The Bill does not specify the criteria for setting expenditure goals, and relies upon a negotiated process with unpredictable outcomes. However, the establishment of an expenditures Board together with the other cost containment provisions of the Bill is likely to result in savings to the health care system.

To illustrate the potential savings achievable through the Federal Expenditures Board, we considered two scenarios. In the first scenario, we assume that the Board succeeds in slowing the growth in per-capita hospital and physician spending, currently projected to grow at twice the rate of inflation (8.2 percent), to about 175 percent of the rate of inflation (7.2 percent). In the second scenario, we assume that the rate of growth in hospital and physician spending is reduced to about 150 percent of the rate of inflation (6.2 percent).

Under the first scenario, the net reduction in health spending (i.e., health spending reductions offset by increased utilization for previously uninsured persons) would be $83.9 billion over the 1993 through 1997 period (Table 2). The net reduction in health spending under the second scenario would be $215.3 billion over the same period.

While savings are difficult to project, the savings estimated in our second scenario represent a high-range estimate of what might be reasonably expected to occur under the program. For example, studies indicate that in states with hospital rate setting programs, the rate of growth in health spending has been reduced by 30 percent.[1] By comparison our second scenario assumes that the rate of growth in health spending is slowed by 25 percent. Moreover, our second scenario implies a reduction in health spending of about 4.0 percent over the 1993 through 1997 period which seems modest in the context of expenditure budgeting.

Under the second scenario, health spending as a percentage of GNP would start to level-off at between 14.1 percent and 14.3 percent beginning in 1995 (Table 3). By comparison, health spending is projected to reach 15.7 percent of GNP by 1997 under current policy.

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[1] C.J. Schramm, S.C. Renn, and B. Biles, "New Perspectives Onstate Rate Setting," *Health Affairs*, Fall 1986.

D. Differing Versions of the Health America Act

It is important to distinguish between the two versions of the Health America Act. On September 23, 1991, testified before the Senate Finance Subcommittee on Health for Families and the Uninsured on the potential for cost containment under the Health American Act which preceded the Labor and Health Committee Amendments. I testified that under that version of the Bill, the net impact of the Health America Act would be a reduction in National Health Spending of $46 billion over five years. However, this testimony did not reflect the Senate Labor and Health Committee Amendments which greatly enhance the effectiveness of the Federal Health Expenditures Board. We estimate that these Amendments increase the potential net savings under the Act to $215 billion over the 1993 through 1997 period.

PART TWO: ENROLLMENT IN PUBLIC AND PRIVATE INSURANCE PROGRAMS UNDER THE HEALTH AMERICA ACT

Under the Health America Act, workers and dependents in firms that pay the tax rather than provide insurance would be covered under a public program. Although many employers will find it advantageous to cover their workers under the public plan, we estimate that if the Health America Act were implemented in 1993 with a payroll tax of 8.0 percent, the number of persons with private health insurance would actually increase. The number of workers and dependents with private insurance would increase from 141.0 million persons per month under current policy to 143.4 million persons per month under the Health America Act. While many firms that now offer insurance will shift to the public plan (about 16 million persons), about half of workers in firms that do not now offer insurance will elect to provide private insurance resulting in a net increase in private coverage of 2.4 million persons.

Our analysis also indicates that the Senate Labor and Health Committee version of the bill, which includes greatly enhanced cost containment provisions, would avert a substantial erosion of private health coverage in future years. Our study indicates that in the absence of significant cost controls, the rising cost of health care will over time make it increasingly attractive for employers to abandon private coverage in favor of the public plan. However, this shift to the public plan over time is largely averted by the substantial reduction in the rate of growth in health spending that can be achieved under the Senate Labor and Health Committee version of the bill.

The methods used to develop these estimates are described below.

A. Employer Response

The Health America Act requires employers to either provide insurance for workers and dependents, or cover these individuals under a public program by paying a payroll tax. An employer who decides to provide insurance must pay 80 percent of the premium for a specified minimum benefits package for all persons working 17.5 or more hours per week to be exempt from the payroll tax. In cases where the employer chooses to pay the tax rather than provide insurance, all workers in that firm and their dependents will become covered under the public plan where they will receive coverage comparable to that required under the minimum benefits standard. In addition, all non-workers will be covered under the public plan.

We developed estimates of the number of persons enrolled in private insurance and the public plan. In developing these estimates we assume that employers will cover their workers under the public plan wherever this is the least costly alternative available to them. We estimated the number of workers and dependents who are in firms that would find it advantageous to cover their workers under the public plan using the Lewin-ICF Health Benefits Simulation Model (HBSM). The model is based upon representative surveys of employer and employee characteristics including:

- A representative sample of employers which provides information on employer health spending, payroll and worker characteristics. These data are based upon a survey of 850 small, medium and large employers conducted for the Small Business Administration.
- A representative sample of individuals which include information on employment characteristics, sources of insurance coverage and health expenditures. These data are based upon the National Medical Care Utilization and Expenditures Survey (NMCUES) which we have updated to reflect more recent data on population characteristics, income, insurance coverage, and health expenditures.

This collection of data provides a basis for estimating the number of employers who would face a financial incentive to enroll in the public plan and estimate the cost of covering individuals under the plan.[2]

1. Firms that Do Not Now Offer Insurance

Among firms that do not now offer insurance, we assume that employers will compare the cost of paying the tax with the cost of providing private insurance that conforms to the minimum benefits package required under the Health America Act. We assume that all employers who find that the payroll tax option is the least costly alternative will elect to cover their workers under the public plan. All employers who find that the cost of insurance is less than paying the tax are assumed to purchase insurance.

While circumstances will very across employers, we estimate that at an 8.0 percent tax rate, firms with an average annual payroll of less than $17,250 per year will generally find if less costly to pay the tax than to purchase insurance. Using HBSM, we estimate that among firms that do not now offer insurance, the average employer share of the cost of insurance under the Health America Act will be about $115 per employee per month ($1,380 per year). Firms with an average payroll of $17,250 will on average be indifferent between paying the tax and purchasing insurance because it is at this point that the cost of insurance equals the payroll tax (i.e., 8.0 percent of $17,250 equals $1,380). Thus, firms with an average payroll which exceeds $17,250 per year will generally find it advantageous to purchase insurance while firms below this average payroll level will find it less costly to pay the tax.

2. Firms That Now Offer Insurance

The problem is more complex for firms that now offer insurance. In firms that now provide insurance, the employer cost of employee health benefits is equal to about 7.5 percent of payroll for workers who have coverage. This suggests, that at a payroll tax rate of 8.0 percent, substantial numbers of persons will shift to the public plan. However, this reasoning overstates the potential for migration to the public plan because it ignores that in many firms, health costs exceed 8.0 percent of payroll only because they offer coverage which is far more comprehensive than that required under the Health America Act.

For example, about 63 percent of all workers who now have employer coverage are covered under a plan which is more comprehensive (i.e., cover more services with lower employee cost sharing) than the plan required under Health America (as measured by actuarial value). For these employers, shifting to the public plan implies a substantial downgrade in coverage for their workforce. Since many of these more comprehensive plans are found in unionized workplaces or in highly competitive labor markets, it is unlikely that significant numbers of employers will adopt such a downgrade in coverage.

Moreover, even if these employers do decide to adopt a coverage downgrade, they generally will find it less costly to obtain this coverage in the private market. This is because many of the firms with comprehensive benefits plans typically have more highly compensated workforces where the cost of paying the tax would *exceed* the cost of buying the Health America minimum benefits package in the private market. This is illustrated in the following example:

> Consider a firm which in addition to covering the basic physician and hospital care required under the Health America Act, covers dental care, eyeglasses, and prescription drugs. Also, assume that the plan has a lower deductible than the maximum allowed under the Act and the employer pays 85 percent of the premium. This firm exceeds the Health America minimum standard in terms of both covered services and employee cost sharing. Such a firm could easily have health care costs as high as nine or ten percent of payroll. These employers will often find that they can obtain the minimum level of coverage required under the Health America Act in the private market for an amount which is equal to six or seven percent of payroll. In these instances, an employer who decides to downgrade to the Health America standard will find that it' is less costly to purchase the Health America benefits package in the private market than to pay the eight percent payroll tax. Moreover, the cost of maintaining their existing level of coverage will be reduced under Health America as working spouses now covered as dependents become covered under their own employers' plans.

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[2] For a more detailed description of the data and methods used see: Lewin-ICF, "The Health Benefits Simulation Model (HBSM)," Technical Documentation, Submitted to the Office of Research, Health Care Financing Administration, April 13, 1990.

In our analysis, we assume that employers that now offer insurance will shift to the public plan only in instances where the cost of paying the tax is less than the cost of purchasing the minimum benefits package on the private market.

B. Enrollment in The Public Plan

With a payroll tax of 8.0 percent, we estimate that there will be an average of 43.2 million workers and dependents per month enrolled in the public plan if the program were fully implemented in 1993 (Table 4). In 1993, there will be about 45.6 million workers and dependents per month who under current policy would be in noninsured employment: of whom about 26.7 million would become covered under the public plan and 18.9 million would become covered under private insurance. In addition, about 16.5 million workers and dependents will be shifted to the public plan from existing private plans by employers who decide to discontinue private coverage.

Private coverage will actually increase by about 2.4 million persons under a 8.0 percent tax rate. This is because the increase in private coverage among persons who are now in firms that do not offer insurance (18.9 million) will exceed the number of persons shifted from private coverage to the public plan (16.5 million).

Enrollment in the public plan is very sensitive to the level of the tax rate. In general, higher tax rates discourage enrollment in the public plan while reductions in the tax rate tend to make participation in the public plan more attractive. For example, if the tax rate were increased from 8.0 percent to 10.0 percent, the number of workers and dependents enrolled in the public plan would decline from 43.2 million persons to 21.2 million persons. At a tax rate of six percent, enrollment in the public plan would rise to an average of 76.7 million persons per month.

Regardless of the level of the tax rate, there will always be a revenue shortfall under the plan. That is, revenues for workers and dependents under the public plan, including employer tax payments and employee contributions, will be insufficient to cover the cost of providing coverage to persons covered under the public plan. This is because employers will generally pay the tax, thus covering their workforce under the public plan, only if this is less costly than providing insurance. Because the cost of covering these individuals under the public plan is largely the same as the cost of private coverage, we can expect that public plan revenues will always be less than the cost of services provided to public plan enrollees.

With a payroll tax rate of 8.0 percent, the revenue shortfall under the plan will be about $9.4 billion in 1993. The amount of the shortfall will generally increase as the tax rate is reduced. The revenue shortfall, which will be covered by general revenues, can be thought of as a subsidy to lower wage workers.

The estimates presented in Table 4 apply only to workers and dependents. In fact, non workers who are not otherwise covered under Medicare will be covered under the public plan as well. Average monthly nonworker enrollment under the public plan would be 41.5 million persons, many of whom are former Medicaid enrollees who are transferred to the public plan under the Health America Act.

C. Public Plan Enrollment in Future Years

A major concern with the "Pay or Play" approach is that enrollment in the public plan will become increasingly attractive to employers as the cost of care increases relative to the payroll tax rate. For example, we estimate that at an 8.0 percent payroll tax rate, about 23.2 percent of all workers and dependents would become covered under the public plan in 1993. Based upon the current projected rate of growth in health spending, public plan enrollment would rise to about 30 percent of all workers and dependents by the year 1997 in the absence of effective controls on health spending.

This growth in the public plan would be largely averted under the version of the Health America Act reported by the Senate Labor and Health Committee. Under this version of the bill, the rate of growth in health spending will be controlled through a provider rate setting system implemented through the Federal Health Expenditures Board. Due to these cost controls, private insurance will continue to be an attractive alternative to the public plan for most employers. We estimate that under the Labor and Health Committee version of the bill, this growth in public plan enrollment over time is largely eliminated with public plan enrollment stabilized at about 25 percent of all workers and dependents through 1997.

Our estimates indicate that enrollment in the public plan over time will be substantially more stable with the Senate Labor and Health Committee cost control amendments than without. This analysis illustrates that effective cost containment is a critical element in maintaining the stability of the Pay or Play approach over time. Indeed, no health care financing system will be stable as long as the cost of care continues to grow substantially faster than our national income.

The Health America Act increases the cost of compensation for workers who are not now covered by insurance. It is unlikely that employers will absorb the full amount of this increased cost in the form of reduced profits. Employers are likely to either: (1) raise prices, thus passing the cost of complying with the Act on to consumers; or (2) reduce labor costs by lowering wages or reducing employment. The available evidence suggests that employers would probably adopt some combination of these responses.

Perhaps the greatest concern is the potential for lost employment. Most economists expect that the potential loss of jobs will be concentrated among minimum wage workers where the employers do not have the option of passing on the cost of insurance in the form of lower wages. Under the Health America act, the employers' cost of compensation for a worker at the minimum wage would increase by 35 cents per hour (i.e., eight percent of the minimum wage ($4.25) for workers covered under the public plan. Based upon a review of empirical studies of past increases in the minimum wage, we estimate a loss of between 23,000 and 63,000 jobs under the program. This is consistent with other job loss estimates for employer based insurance expansions prepared by Dr. Kenneth Thorpe, Dr. Karen Davis and the Congressional Budget Office (CBO).

This loss of employment must be viewed in the context of trade-offs. While some job loss is expected, Health America will provide improved access to needed health care for tens of millions of Americans. Moreover, the Act would protect many thousands of uninsured and underinsured families from the financial ruin that so often accompanies a major illness. For example, we estimate that the number of non-elderly families with uninsured medical expenses in excess of 30 percent of family income will be reduced by about 40 percent (700,000 families) under the Health America Act.

The methods used to develop these estimates are discussed below.

A. Potential Job Loss

The potential for job loss under the Health America Act is explained by economic theory on the relationship between wage levels and worker productivity. In the long run, employers will not pay workers more than the value of their productive output (i.e., in economic jargon, employers will pay a wage such that the marginal cost of additional labor equals the worker's marginal product). Thus, if an employer's compensation costs increase, as they would under the Health America Act, the employer can be expected to reduce other forms of compensation such as wages and pensions so that total employee compensation costs are consistent with the value of worker outputs. This suggests that employers will seek to offset the added cost of insurance in the form of lower wages rather than reducing the level of employment.

The one major exception to this theory is among minimum wage workers. Employers of minimum wage workers are essentially prohibited from lowering wages to offset the added cost of insurance under the Health America Act. These employers may reduce minimum wage employment so that total compensation costs are consistent with the value of productive outputs.

Under the Health America Act, the cost of compensation for minimum wage workers is effectively increased by 35 cents per hour. That is, an employer who covers their workers under the public program by paying the eight percent payroll tax will incur an additional 35 cents per hour in compensation costs (i.e., eight percent of $4.25 per hour). Thus, the effective minimum wage would increase from $4.25, where it has been since 1991, to $4.60 per hour in 1993. [Interestingly, the effective minimum wage after adjusting for inflation between 1991 and 1993 would be roughly the same as it was in 1991.] The question, therefore, is how many jobs will be lost due to a 35 cents per hour increase in the effective minimum wage?

The effect of the minimum wage on employment has been widely studied by several leading labor economists. These studies reveal an unusual degree of consensus on the impacts of the minimum wage on employment. These studies generally find that the loss of jobs is small and-concentrated primarily among teenagers. However, most teenagers are exempt from the Health America Act because they are either covered as dependents under their parent's plan or they work less than 17.5 hours per week. Although minimum wage increases result in some job loss among young adults (i.e., 18 to 24) studies have generally found little measurable impact on adult employment. However, it should be noted that studies of minimum wage impacts on adults are far less numerous than are studies of the impact on youth employment.

In earlier testimony before the Senate Labor and Health Committee, Dr. Kenneth Thorpe indicated a potential loss of 50,000 jobs under the Health America Act (a

reduction in total employment of less than one tenth of one percent). This estimate was based upon recent research by Wellington indicating that a 10 percent increase in the minimum wage is associated with a 0.6 percentage point reduction in the employment to population ratio.[3] Based upon a survey of empirical research compiled by Dr. Charles Brown and others, we estimate a potential loss of between 23,000 and 63,000 minimum wage jobs. This estimate was developed based upon the range of estimated changes in employment reported in the literature for an eight percent increase in the minimum wage.[4]

These estimates are largely consistent with earlier testimony by the Congressional Budget Office (CBO) on the impact of S. 1265/H.R. 2508. This bill would have required employers to provide private insurance to all workers without giving the employer the option to cover their workers under the public plan. CBO estimated that this bill, which represented nearly twice the increase in the effective minimum wage required under Health America, would result in up to 100,000 jobs lost. Presumably, CBO's job loss estimate would be lower for the Health America Act.

B. Likely Employer Responses

Given that job loss is expected to be small under the Health America Act, we can expect that employers' primary response will be to pass on the cost of complying with the Act in other ways. Many economists note that such increases in compensation costs often have "shock" effects that stimulate new efficiencies in production which could absorb some of the added costs of health America. However, it is likely that employers will respond by either reducing wages over time or increasing prices.

CBO has testified that it would take up to three years for employers to implement these reductions in compensation. Wage adjustments will typically take the form of lower wage increases than would have been expected under current policy. This suggests that a gradual phase-in of coverage requirements, such as the phase-in schedule called for under Health America, could minimize the disruptions associated with these compensation adjustments.

There is also some evidence that employers will pass on much of the increase in costs to consumers in the form of higher prices. The populations affected by the Act tend to be concentrated in certain sectors of the economy such as the food service industry. Under Health America, all producers in these sectors will face roughly the same increase in costs so that prices could increase throughout that sector without putting individual producers at a competitive disadvantage. To the extent that prices increase, the cost of the coverage expansion will ultimately fall on consumers.

APPENDIX A.—METHODOLOGIES USED TO ESTIMATE THE IMPACT OF COST CONTAINMENT INITIATIVES UNDER S. 1227

The methodology we used to estimate the impact cost containment initiatives under S. 1227 is described below:

A. NATIONAL HEALTH SPENDING: CURRENT PROJECTIONS

Estimates of national health spending under current policy in future years are based upon health spending projections developed by the Health Care Financing Administration (HCFA). HCFA projects that per-capita health spending will grow by about 8.6 percent per year through 2000 which is about double the projected rate of inflation.[5]

B. UTILIZATION INCREASE FOR PREVIOUSLY UNINSURED PERSONS

Utilization of health services by previously uninsured persons is expected to increase as these individuals become insured (either through employer coverage or the public plan). Utilization of health services by previously uninsured persons is assumed to adjust to the levels reported by insured persons with similar age, sex, income and health status characteristics. The total increase in national health spending for newly insured persons would be about $14.7 billion if the program were fully

[3] Alison J. Wellington, "Effects of the Minimum Wage on the Employment Status of Youths: an update," *Journal of Human Resources*, 26(1)1990:27–45.

[4] Based upon a review of several empirical analyses of the minimum wage, Brown reports a range of percentage changes in employment that would be expected with a 10 percent change in the minimum wage. We adjusted this range of percentage changes to reflect the fact that Health America implies an eight percent increase in the effective minimum wage and applied these percentage changes to the portion of the workforce that is covered by the Health America coverage requirements. See: Charles Brown, Curtis Gilroy, and Andrew Kohen, "The effect of the Minimum Wage on Employment and Unemployment," *Journal of Economic Literature* Vol. XX (June 1982), pp. 487–528.

[5] Health Care Financing Review/Summer 1987/ Volume 8, Number 4.

implemented in 1992 which represents an increase in national health spending of about two percent. However the increase in insurance coverage and the resulting increase in utilization under S. 1227 would be phased-in between 1993 and 1997 as follows:

- Beginning in 1993, the employer coverage provisions of the Bill would apply to only firms with 100 or more workers. Coverage of pregnant women and children under the public plan would also being in this year.
- In 1996, the employer coverage provisions will be extended to all firms with 25 or more employees.
- The employer coverage provisions will apply to all firms beginning in 1997. Coverage of non-working adults under the public plan will also begin in this year.

This phased expansion of coverage is reflected in the utilization estimates shown above.

C. ADMINISTRATIVE SAVINGS UNDER THE PUBLIC PLAN

We estimate that under the provide-or-contribute model about 15 million workers who are currently insured under private employer health plans will be shifted to the public plan. These include workers and dependents in firms that now offer insurance who find it less costly to pay the tax than offer insurance.

This will reduce administrative costs by shifting individuals from small employer plans where administrative costs average about 28 percent of incurred claims to the public plan where administrative costs for small groups are estimated to be only about 15 percent of claims.[6] Total savings in administrative costs are estimated to be about $800 million in 1992.

The legislation also calls for insurance market reforms which will limit underwriting practices resulting in reduced insurer administrative costs. Estimated savings resulting from these changes are discussed below.

D. REDUCE UNNECESSARY AND INEFFECTIVE CARE

The proposal includes two provisions designed to reduce costs associated with unnecessary and ineffective treatments. These include:

Expanded Development of Medical Practice Guidelines

The proposal calls for expanded use of medical practice guidelines in both public and private sector programs. A growing body of research exists on Medical practice guidelines which would be implemented under the program.

Medicare—It is estimated that research performed to date on 20 major procedures has produced practice guidelines which if fully implemented would result in savings to Medicare of up to $2.5 billion (in 1991 dollars).[7] We assume that the savings from these practice guidelines will phase-in over a three year period beginning in 1992. Medicare savings from ongoing medical guidelines research is assumed to increase by $500 million per year (in 1991 dollars) starting in 1995.

Private Sector—It is estimated that existing practice guidelines data could reduce premium costs in employer based plans by as much as three percent.[8] We assume that these savings will occur primarily among persons not already enrolled in plans with selective contracting arrangements. Savings are assumed to be phased-in over a three year period. Potential savings are assumed to increase by 0.25 percent of premiums beginning in 1995 as new research becomes available.

Technology Assessment

A program would be initiated to determine the appropriate use and reimbursement levels for new technologies. For illustrative purposes we have assumed that this program induces a 12 month lag in the adoption of new technologies. We estimated the impact of this assumption by imposing a 12 month lag in the portion of health care inflation attributed to service intensity (It is estimated that about 25 percent of health care inflation is attributed to a growth in service intensity).[9]

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[6] Estimates of administrative loads under various public and private insurance models are based upon estimates provided by the Congressional Research Service.

[7] Unpublished data provided by Karen Davis of Johns Hopkins University.

[8] Presentation by Mark Chasim to the Florida Task Force on Private Sector Health Care Responsibility.

[9] Based upon Levin/ICF analysis of HCFA data on the components of health price inflation.

E. PROMOTE COMPETITION

Provider competition would be encouraged by requiring providers to publish their rates. These data would encourage providers to be more competitive and would facilitate selective contracting. This competitive model is used in California and is estimated to have reduced the annual rate of growth in hospital costs by about 10 percent.[10]

We assume that under this provision, the growth in hospital spending will be slowed by 10 percent per year. Savings are assumed to occur only in states that do not now have hospital rate setting systems or a comparable competitive model (these include California, New York, Maryland, New Jersey and Massachusetts). Savings are assumed to be phased-in over a three year period.

F. ENCOURAGE MANAGED CARE

The Legislation includes several initiatives to expand managed care. These include:

Pre-empt State Legislative Barriers

The proposed legislation would pre-empt all barriers to selective contracting, utilization review and other managed care practices. We assume that this will result in a 10 percent increase in the number of workers in HMO's.[11] We also assume that HMO's will reduce health spending for newly covered groups by about 10 percent. These savings are assumed to be phased-in over the course of three years.

Small Business Access to Managed Care Plans

Carriers would be required to offer managed care options to all small groups. We assume that HMO enrollment among firms with under 25 employees would rise to the level observed in large firms. Managed care plans are assumed to reduce costs by 10 percent for workers who enroll. These savings are assumed to be phased-in over the course of three years.

Provide Managed Care in The Public Program

HMO's will be made available to workers covered under the public plan. We assume that the percentage of workers enrolling in these plans will be comparable to the percentage of privately insured workers covered under HMO's. Savings are estimated to be 10 percent for persons who become covered under these plans. Savings are assumed to be phased-in over a three year period.

G. PRE-EMPT STATE MANDATED BENEFITS

The legislation establishes a federal minimum benefits standard which pre-empts state mandated benefits. State mandates include: newborn care (46 states), psychiatric care (37 states), chiropractors (35 states), Dental care (27 states) and other services. State mandated benefits have been estimated to add about 15 percent to the cost of health insurance.[12]

Of the benefits required by states, the federal standard would require coverage of psychiatric and newborn care which accounts for about 53 percent of the cost of state mandated benefits. Thus 47 percent of the cost attributed to state mandates (about seven percent of premiums) is potentially eliminated. These savings do not apply to self-insured plans because they are already exempt from state benefit mandates under ERISA.

We assume that half of all employers who now purchase insurance will eliminate coverage for state mandated benefits that are not required under the federal benefits standard (i.e., some may wish to retain dental coverage etc.). Utilization of these services for persons in plans that discontinue these benefits is assumed to decline by about 20 percent.[13]

H. ADMINISTRATIVE COSTS

The legislation includes several initiatives to reduce administrative costs in private insurance. These include:

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[10] James Robinson and Harold Luft, "Competition, Regulation, and Hospital Costs, 1982 to 1986," JAMA, November 11, 1988, Volume 260, No. 18.

[11] About 15 percent of all workers are in a Health Maintenance Organization. GHAA's National Director of HMOs, 1990 edition.

[12] Jon Gabel and Gail Jensen, "the Price of Mandated Benefits," Inquiry 26:419–431 (Winter 1989).

[13] We assume that a one percent change in the price of health services to the individual is associated with a 0.2 percent reduction in utilization of these services.

Insurance Consortia

An insurance consortia is established in each state to consolidate administrative procedures for insurers with small market shares. It will also facilitate the system wide development of cost saving innovations such as "smart" cards for electronic claims transmittal.

Industry analysts estimate that electronic claims transmittal will save about 50 cents per claim for a maximum potential savings of $400 million per year. For illustrative purposes, we assume that under the consortia's leadership, all insurers will convert to the electronic claims transmittal systems over a five year period.

Establish Quality Improvement Agencies

Quality improvement agencies would be created in each state to work with providers to develop a program of continuous quality improvement and implementation of cost effective methods of delivering care. The agency would periodically certify providers as practicing in a cost effective manner thus exempting them from utilization review for a period of up to a year. This will avoid duplicative provider review and focus limited resources on providers who appear to be inclined to over-prescribe.

We assume that the primary impact of this provision will be to improve the effectiveness of utilization review. For illustrative purposes we assume that this provision improves the cost saving potential of managed care plans by 10 percent.[14] These savings are assumed to be phased-in over a period of three years.

Small Business Insurance Reform

The legislation would substantially limit insurer underwriting practices and eliminate pre-existing condition limitations. This will reduce insurer administrative costs associated with approving a policy and reduce claims processing costs by eliminating the need to cross-reference claims with pre-existing condition limitations.

Administrative costs for small employers would be reduced from their current level of about 28 percent of claims to about 21 percent of claims. We developed this estimate by assuming that the portion of administrative costs in small groups attributed to general administration and claims processing costs would be reduced to the levels observed in larger firm size groups (i.e., firms with 25–50 employees).[15] These savings are assumed to be reflected in premiums immediately upon implementation of the program.

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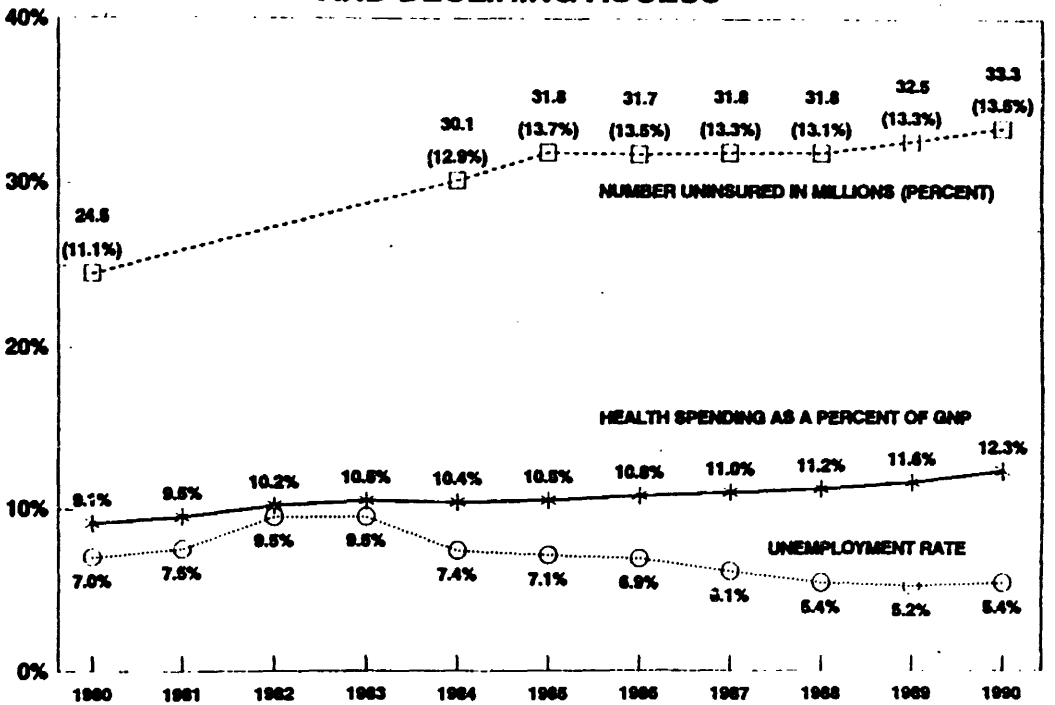
[14] We assume that HMO's reduce costs by about 10 percent and PPO's reduce costs by about five percent. We assumed that the reduction in costs under these arrangements is increased by five percent.

[15] Based upon administrative data developed by Hay/Huggins Inc. for the Congressional Research Service (CRS).

FIGURE 1

THE PARADOX OF INCREASED HEALTH SPENDING AND DECLINING ACCESS



Source: Lewin/ICF analysis of health spending data from the Health Care Financing Administration and March Current Population Survey (CPS) data for 19.. through 1990 adjusted for changes in Survey design in the March 1988-1990 CPS data.

Table 1
CHANGES IN NATIONAL HEALTH SPENDING UNDER SELECTED COST CONTAINMENT INITIATIVES[a]
(In Billions)

Initiatives	1993	1994	1995	1996	1997	Five Year Total
Administrative Savings Under Public Plan	–	(0.35)	(0.38)	(0.42)	(0.73)	(1.88)
Uncessary/Ineffective Care						
Outcomes Research	(1.70)	(3.71)	(6.45)	(7.97)	(9.86)	(29.69)
Technology Assessment	(1.10)	(1.31)	(1.55)	(1.83)	(2.14)	(7.93)
Promote Competition	(0.40)	(0.87)	(1.31)	(1.44)	(1.71)	5.73
Encourage Managed Care						
Pre-empt State Legislative Barriers	(0.10)	(0.22)	(0.36)	(0.39)	(0.43)	(1.50)
Small Business Access to Managed Care	(0.10)	(0.33)	(0.48)	(0.52)	(0.57)	(2.00)
Provide Managed Care in Public Program	–	(0.10)	(0.22)	(0.32)	(0.48)	(1.12)
Pre-empt State Mandated Benefits	(0.60)	(0.65)	(0.72)	(0.78)	(0.86)	(3.61)
Administrative Costs						
Insurance Consortia	(0.05)	(0.11)	(0.24)	(0.39)	(0.57)	(1.36)
Quality Improvement Agencies	(0.18)	(0.39)	(0.65)	(0.71)	(0.77)	(2.70)
Small Group Insurance Market Reform	(1.69)	(1.84)	(2.02)	(2.21)	(2.41)	(10.17)
Total Savings	**(5.92)**	**(9.88)**	**(14.38)**	**(16.98)**	**(20.53)**	**(67.69)**

a Method used to develop these estimates are discussed in Appendix A.

Source: Lewin-ICF estimates.

Table 2

ILLUSTRATION OF THE POTENTIAL IMPACT OF THE "HEALTH AMERICA PLAN" ON NATIONAL HEALTH SPENDING IN 1993 THROUGH 1997

Year	Health Spending Under Current Policy[a]	IMPACT OF HEALTH AMERICA PLAN				
		Utilization Increase for Newly Insured[b]	Impact of Cost Containment Program		Net Impact of Health America Plan	
			Illustrative Scenario #1[c]	Illustrative Scenario #2[d]	Illustrative Scenario #1[c]	Illustrative Scenario #2[d]
1993	$ 888.7	$ 7.2	$ (7.2)	$ (14.2)	$ 0.0	$ (7.0)
1994	976.2	7.9	(15.7)	(31.0)	(7.8)	(23.1)
1995	1,072.7	8.7	(25.7)	(50.8)	(17.0)	(42.1)
1996	1,164.1	13.6	(37.1)	(73.1)	(23.5)	(59.5)
1997	1,263.3	14.7	(50.3)	(98.3)	(35.6)	(83.6)
Total 1993-1997	**$5,365.0**	**$52.1**	**$(136.0)**	**$(267.4)**	**$(83.9)**	**$(215.3)**

a Projections provided by the Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

b Utilization of Health services for previously uninsured persons is assumed to increase to levels reported by insured persons with similar characteristics.

c Assumes that the rate of growth in health spending is reduced by one percentage point per year (i.e., the rate of growth in per capita health spending is reduced to 175 percent of inflation).

d Assumes that the rate of growth in health spending is reduced by two percentage points per year (i.e., the rate of growth in per capita health spending is reduced to 150 percent of inflation).

Source: Lewin-ICF estimates.

Table 3

Illustration of the Potential Impact of the "Health America Plan" on National Health Spending in 1993 Through 1997

	HEALTH SPENDING AS A PERCENT OF GNP		
Year	Current Policy[a]	Scenario #1[b]	Scenario #2[c]
1993	13.8%	13.8%	13.7%
1994	14.3%	14.2%	13.9%
1995	14.7%	14.5%	14.1%
1996	15.0%	14.7%	14.2%
1997	15.4%	15.0%	14.3%

a Projections provided by the Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

b Assumes that the rate of growth in health spending is reduced by one percentage point per year (i.e., the rate of growth in per capita health spending is reduced to 175 percent of inflation).

c Assumes that the rate of growth in health spending is reduced by two percentage points per year (i.e., the rate of growth in per capita health spending is reduced to 150 percent of inflation).

Source: Lewin-ICF estimates.

Table 4
Workers and Dependents Enrolled Under The Public Programa,b

Payroll Tax Rate (In Percent)	Privately Insured[c]	Workers & Dependents Enrolled In Public Plan (Average Monthly Enrollment In Millions) Total Enrollment	Persons Shifted From Existing Employer Plans	Persons In Non-Insured Employment Under Current Law	Revenue Shortfall Under Public Plan[d] (In billions)
5.0	80.8	105.8	55.8	50.0	$49.5
6.0	109.9	76.7	36.0	40.7	28.4
7.0	128.9	57.7	25.0	32.7	13.9
8.0	143.4	43.2	16.5	26.7	9.4
9.0	158.9	27.7	8.6	19.1	4.5
10.0	165.4	21.2	5.6	15.6	2.3

a Assumes employers choose between offering insurance and paying the tax based upon whichever approach minimizes employer costs.

b Tables show the average monthly enrollment figures for workers and dependents. An additional 41.5 million non-workers per month will be covered under the public plan.

c An average of 141.0 million workers and dependents per month will be covered under private insurance under current law in 1993.

d The shortfall is computed as total fund expenditures for workers and dependents, including benefits and administration, less tax and premium revenues received.

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

PREPARED STATEMENT OF CONGRESSMAN CHARLES STENHOLM

Mr Chairman, it is always a pleasure to testify before you and your Committee, and I appreciate the opportunity of coming here with my colleagues Jim Cooper and Mike Andrews to discuss the health reform proposal we will soon introduce on behalf of the Conservative Democratic Forum. Of course, I always appreciate the opportunity to participate in any endeavor which my senior senator is conducting. Between the three of us Texans gathered in this room today, there is no doubt in my mind that we can find the right answers to our health care challenges.

I have always said that in many ways our health care system is the best in the world. Why else would the wealthy of other lands travel here for difficult surgeries? Why else would the rest of the world look to us to develop the technologies which will defeat those diseases which have plagued humanity for centuries? Why else would we have an ever increasing population of octogenarians—and those even older in their 90s and beyond—living fulfilling lives?

But there are other ways that our health care system does not work. The message has been delivered loud and clear to Members of Congress that our health care system is "broke" and, as usual, Members of Congress have a great desire to have the government fix it.

Last fall a number of Members in the Conservative Democratic Forum (CDF)—a group of 60 moderate and conservative Democrats within the House of Representatives—began discussing the void we felt existed in the health care reform debate occurring in Congress currently. We agreed that improvements needed to be made in the affordability and accessibility of health insurance for Americans. But we were not convinced that it is necessary to destroy our private enterprise system of insurance and health delivery; nor is it necessary to put thousands of Americans out of work by burdening their small business employers to the point where they were forced out of business.

We felt that the majority of House Democrats, not to mention American consumers, were looking for a plan that was significant enough to actually make real changes in our health delivery system, but not one that wrought the wholesale, enormously costly changes which were commonly being discussed with national health care or "pay or play" models.

It reminds me of the story I heard where a mother walked into her house and noticed that her five children were all huddled around something in her newly carpeted living room. Noting their excited chatter, the mother walked over to see what the clamour was all about and found in the middle of the group a family of baby skunks. Fearing for the aroma that might soon be spread if the animals became agitated, she screamed, "Run, children, run." And they all did run to different corners of the house—each with a skunk in hand.

The American public has been hollering to the Congress "Run, Act, Do Something!!" And what we felt some of our health care leaders did was grab a skunk and run to different parts of the Congress. Some grabbed a nationalized health insurance skunk, some grabbed a "Play or Pay" skunk and others grabbed new and different skunks.

We kind of thought we could come up with something better than a skunk. It was then that we appointed a CDF Health Reform Task Force, which in May made our first public announcement of the ideas we are submitting for consideration by the Congress and the health care consumers of America. Some of the ideas in our plan came from a variety of other bills seeking to improve our health system. For example, we borrow heavily from your insurance reform, Mr. Chairman. Other parts of our proposal involve innovative, new ways to deal with access and cost of health care.

One thing that quickly became clear to us in the CDF was that everyone must be asked to share in the responsibility of improving our health system and its costs. The federal government must increase funding for Medicaid, Community and Migrant Health Centers, and things like childhood immunizations and other preventive care.

Hospitals and doctors must do much more in the areas of disclosing costs and outcomes information, following proven strategies for health delivery and giving consumers the opportunity to make better choices.

Insurance companies must reform their exclusive policies and make uniform their claims and forms.

Individuals must accept a greater responsibility for their own state of health through preventive care and paying at least a minimum amount for all other care.

But in addition to the new responsibilities of our plan, there are also some "goodies" for everyone. For hospitals, there is an effort to deal with the anti-trust

laws that prevent cooperative agreements among hospitals, if those agreements can maintain consumer choice and reduce costs.

For both hospitals and doctors, there is long-overdue malpractice reform.

For senior citizens there is new Medicare coverage for things such as mammograms and certain cancer screening, and for children there are immunizations.

To try to capsulize, our proposal seeks to create a market where consumers can shop for health care, based on cost and quality like any other consumer product. We want consumers to have all the information that will help them make the best health care decisions possible, and will encourage them to make those decisions while they are healthy, not when they are sick and in a bad position to be wise consumers.

One of the central philosophies of the Conservative Democratic Forum is fiscal responsibility. That means that when this bill is introduced within a few weeks, we will have agreed upon financing for the bill.

We believe that this proposal fills a significant void in the health care debate and we will be working towards these principles of cost containment and accessibility as we debate health reform for this nation.

Of course, at this point it is anyone's guess as to whether we will be able to have comprehensive health reform signed into law this year. Even if all we do is pass smaller pieces of the pie, the Conservative Democratic Forum wants to makes sure that we are part of it all, trying to help determine whether that pie will be cherry, chocolate or coconut cream.

Thank you for your attention to our ideas. I will now turn to Congressman Jim Cooper of Tennessee, the Chairman of the CDF's Health Task Force. Both Jim and Mike have done a superb job of putting together the specifics of our bill and will be able to provide you with some additional details at this time.

Proposal of the Conservative Democratic Forum Task Force on Health Care Reform

HIGHLIGHTS

Cost Control

• **Cost control through managed competition:** Providers and insurance companies will form health partnerships which will be publicly accountable for costs and medical outcomes. An SEC-like board will be established to set the scope of uniform, effective health benefits, standards of accountability, and standards for insurance. Health partnerships will be required to disclose cost and outcomes information so consumers can shop for the most effective h al ı care.

• **Change in tax treatment of insurance:** Employers will be allowed to deduct basic insurance costs, but not the excess costs of policies which exceed the scope of basic benefits. Basic insurance policies must require co-payments to make consumers cost-conscious, and must be provided through publicly accountable health partnerships.

• **Preventive health** will be strongly stressed, including full immunization of children, substantially increased prenatal care, and the promotion of healthier lifestyles.

• **Malpractice reform** will reduce the costs of expensive litigation and the cost of defensive medicine.

• **Paperwork reduction:** Insurance companies will be required to develop uniform claim forms, and the federal government will devise a plan to significantly reduce paperwork.

Universal Access

• **Access for low-income individuals:** A new federal program will purchase insurance for all people below 100% of the poverty level. Individuals and families between 100% and 200% of the poverty level will receive a federal subsidy for the purchase of insurance. States will gradually assume responsibility for long-term care.

• **Insurance reform:** More small business will be able to afford insurance by joining Health Plan Purchasing Cooperatives. As a member of a cooperative, small businesses will be required to make a choice of insurance plans available to their employees, but will not be required to pay for health insu. ince. Employees of all businesses will benefit from a prohibition on pre-existing conditions limitations which will prevent "job-lock." Insurance companies will not be allowed to use "experience rating" to charge higher rates for individuals who have had a history of higher medical expenses.

• **Tax fairness:** All employees, including the self-employed, will be allowed to deduct 100% of basic insurance costs (Under current law, the self-employed can deduct only 25% of costs).

• **Basic access:** Funding for Community Health Centers and National Health Service Corps will be substantially increased.

SUMMARY

Managed Competition — The Heart of Cost Control

Providers, Insurance Companies, and Patients

Through changes in the tax code, we strongly encourage providers and insurance companies to form Accountable Health Partnerships (AHPs) — improved and expanded versions of today's Health Maintenance Organizations, Preferred Provider Organizations, and other group practices. AHPs will be allowed to organize in whatever way they believe will allow them to provide care most efficiently.

Like today's HMOs and other groups, AHPs will be responsible for looking after the total health of individuals in a cost-effective way, and will offer insurance and health care as a single product. Unlike today's health groups, they will be publicly accountable for costs and outcomes, and will be judged on their overall effectiveness in taking care of people.

AHPs will have to offer insurance in a dramatically different way than it is offered today. In our current system, insurers can "cherry-pick" the healthiest individuals, and deny coverage or charge extremely high rates for others. Insurance companies can also deny coverage for individuals with pre-existing medical conditions. Under our proposal, those practices will be prohibited.

CDF Proposal: We would allow AHPs to provide tax-advantaged health insurance only if they meet federal standards:

- AHPs must offer a standard health plan based on federally-defined uniform, effective health benefits, and they will be publicly accountable for medical outcomes. They may offer more comprehensive plans, but employers who purchase those plans will receive a tax break only for the least costly package of basic benefits.

- AHP plans must eliminate experience rating, where premiums vary based on how sick people have been and how many claims they have had in the past. Premiums will be allowed to vary only based on factors like age and geographic location.

- AHP plans will not be allowed to disqualify individuals based on pre-existing medical conditions.

- AHP plans must require copayments for medical services (except for preventive care).

- AHPs will be allowed to contract with "Centers of Excellence" for costly high-tech or specialized services.

- AHPs will be exempt from all state mandates on benefits.

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Small Businesses

Small businesses face two major disadvantages that discourage them from providing health insurance:

1. As much as 40% of the premiums paid by small businesses goes toward administrative costs of health insurance.

2. Small businesses do not have enough employees to spread the risk of insurance around, and if even a few employees have high medical expenses, insurance can quickly become unaffordable.

To reduce administrative costs and spread risks, we will require small businesses (up to 100 employees) to join a Health Plan Purchasing Cooperative (HPPC), though they will not be required to pay for coverage for their employees. In a sense, HPPCs will act as the health benefits manager for small businesses.

- HPPCs will be state chartered, not-for-profit organizations, with exclusive geographic territory. States will have the option to allow businesses of up to 10,000 employees to join their HPPC.

- HPPCs will make unnecessary the burden of COBRA insurance continuation coverage for small businesses.

- HPPC administrative expenses will be financed by a surcharge on individual premiums; small businesses will not have to pay to join a HPPC.

CDF Proposal: Small businesses will be required to join a HPPC, but will not be required to make a direct contribution for health insurance.

Universal Access

Medicaid Reform

Medicaid is the main program providing health services to the poor. The program is financed through matching funds from the federal government to the states, and covers both acute care (e.g. hospitals and physicians) and long-term care (e.g. nursing homes and care for the mentally disabled).

Medicaid has a complicated set of requirements for eligibility, and today only covers about half of the people below the poverty line. The criteria for coverage vary substantially from state to state. In general, eligibility for Medicaid is linked to eligibility for welfare, though pregnant women and children may receive Medicaid coverage even if their incomes are above the welfare cut-off.

CDF Proposal: We will replace Medicaid with a new federal program which will gradually phase in acute care coverage for all individuals below the poverty line. Individuals will be members of a Health Plan Purchasing Cooperative, and will have a choice of health plans. The federal program will pay premiums on their behalf. Individuals and families above the poverty line but below 200% of poverty will also be part of the HPPC and will receive a partial subsidy for the purchase of insurance. States will gradually assume responsibility for long-term care.

States will benefit if acute care is financed completely with federal funds, because acute care is growing much faster than long-term care. In FY 1990 acute care was 55% of Medicaid spending. In FY 1991 acute care was 59% of Medicaid. Not only will all of the states save money by only having responsibility for long-term care, but they will have the flexibility to try innovative approaches.

Eligibility for this new program will be separated from eligibility for welfare, and the program will operate much more like private insurance. Medicaid will adopt the same uniform, effective health benefits as private insurance. All participants will be required to make nominal co-payments for all but preventive services.

Schedule of coverage:

Income Level (As a % of poverty)	Premium Paid
Below 100%	0
100-200%	Sliding Scale based on income

COSTS:

Based on 1991 expenses, extending Medicaid coverage to all individuals below 100% of poverty would cost $14.2 billion.

The subsidy provided on a sliding scale will range from zero to $15.5 billion, depending on available revenues. With maximum funding, the subsidy would average $400 for individuals and $1,200 for families.

The transition to making acute care 100% federal will cost approximately $2 billion a year.

Access in Rural and Other Underserved Areas

Practitioners are scarce in many rural areas, and there are few opportunities for competition. In those areas an Accountable Health Partnership could include all providers in the area, and the providers would be held to the same standards of accountability as all other providers. Rural health partnerships will be allowed to contract for capital-intensive or high-tech services.

CDF Proposal: We would substantially improve access to basic care for rural and inner-city residents through a $100 million increase in funding for Community and Migrant Health Centers (current funding $594 m.), and through a $25 million increase in funding for the National Health Service Corps (Current $120m.).

COST: $125 million

Tax Treatment of Health Insurance

Current law provides two tax benefits for the purchase of health insurance:

1. Individuals are allowed to exclude from their income any amount their employer pays toward health insurance coverage. This tax exclusion is available for any kind of health insurance policy, and because it offers a subsidy of as much as 31% on the purchase of insurance, it has been pointed to as one of the factors contributing to health inflation. This subsidy will cost the federal government $38 billion in fiscal year 1992.

2. Most businesses are allowed to deduct the full cost of any health insurance they provide to their employees. However, the self-employed and certain businesses are only allowed to deduct 25% of this cost.

CDF Proposal: To discourage inflationary "Rolls-Royce" health insurance policies, which don't control costs, we will limit the amount that any business can deduct for health insurance to the least costly health plan (providing federally-defined minimum benefits) offered by an accountable health partnership in their region.

Employers will have to pay tax on any coverage they provide above the basic benefits or if they purchase coverage from a non-accountable insurer. This approach will not affect the employees' tax exclusions described above.

We will equalize the deductibility of health insurance by allowing all businesses (including self-employed) to deduct 100% of the minimum cost of health benefits in their region.

COSTS:

Limiting the deduction to the minimum cost of a health plan in a region will save an estimated $5 to $10 billion annually.

National Health Board and Accountability

Managed competition will work only if the market is carefully overseen and providers are held publicly accountable for the care they provide.

CDF Proposal: We will establish an independent national health board with responsibility to oversee the health market, much like the Securities and Exchange Commission oversees the financial market. The board will:

- Establish Basic Uniform Effective Health Benefits
- Establish Standards for reporting prices and health outcomes

* Recommend limited antitrust exemptions for hospitals and physicians to prevent the duplication of costly high-tech items and services

• The board will be designed to function independently. Its recommendations will be submitted to Congress and will have to be approved or rejected on an up-or-down vote.

• The board will be advised by expert industry boards which will focus on benefits and insurance standards (this will work in much the same way as the Federal Accounting Standards Board advises the SEC).

• Revenues to run the board would come from a small fee (maximum $5) per enrolled member in AHPs.

Consumer Information

Accountable Health Partnerships will be required to report full information on the outcomes of treatments and the costs of their plan. This information will be given to consumers and employers to allow them to choose the most efficient providers. The information will also be used by providers to help them change their practice styles.

This new accountability is fundamentally different from the current practices of some managed-care groups, where doctors are second-guessed on a case by case basis. Under the CDF proposal, information will be gathered on a statistically significant population basis, and doctors should have more clinical autonomy.

CDF Proposal: AHPs which do not report the required information will not be allowed to offer tax-advantaged health insurance.

Other Cost Control Provisions

Preventive Health and Personal Responsibility

The best way to reduce medical costs for individuals is to keep them healthier. The defects of our current system include our failure to immunize all children, failure to provide adequate prenatal care and failure to aggressively promote healthy lifestyles.

CDF Proposal: Following the recommendations of the federal Healthy People 2000 report, we would ensure 100% childhood immunization and improved prenatal care (see new Medicaid program). We would also expand public health program to control diseases like tuberculosis and would significantly expand programs to combat smoking, alcohol and drug abuse, and otherwise promote healthy lifestyles.

We would also increase preventive health services for older Americans by expanding Medicare coverage for colorectal cancer screening, mammograms and flu vaccines. (This approach is based on the Bentsen-Rostenkowski Medicare Preventive Services Act — HR 2565 and S 1231).

Malpractice Reform

Unnecessary litigation and defensive medicine have contributed to rising medical costs, and must be controlled as part of health reform. In some regions of the country the high cost of liability insurance has not just driven up costs, but has reduced access to care, especially for high-risk services like obstetrics.

CDF Proposal: We would make substantial changes in the law, including limiting non-economic damages, allowing periodic payment of large awards, and reducing unreasonably long statutes of limitations. We would supersede state laws, except where they are more stringent than federal law. These changes would be combined with new accountability requirements which would identify sub-standard providers. (This approach is based on HR 3516, sponsored by Mr. Kyl and Mr. Stenholm).

Paperwork Reduction and Administrative Simplification

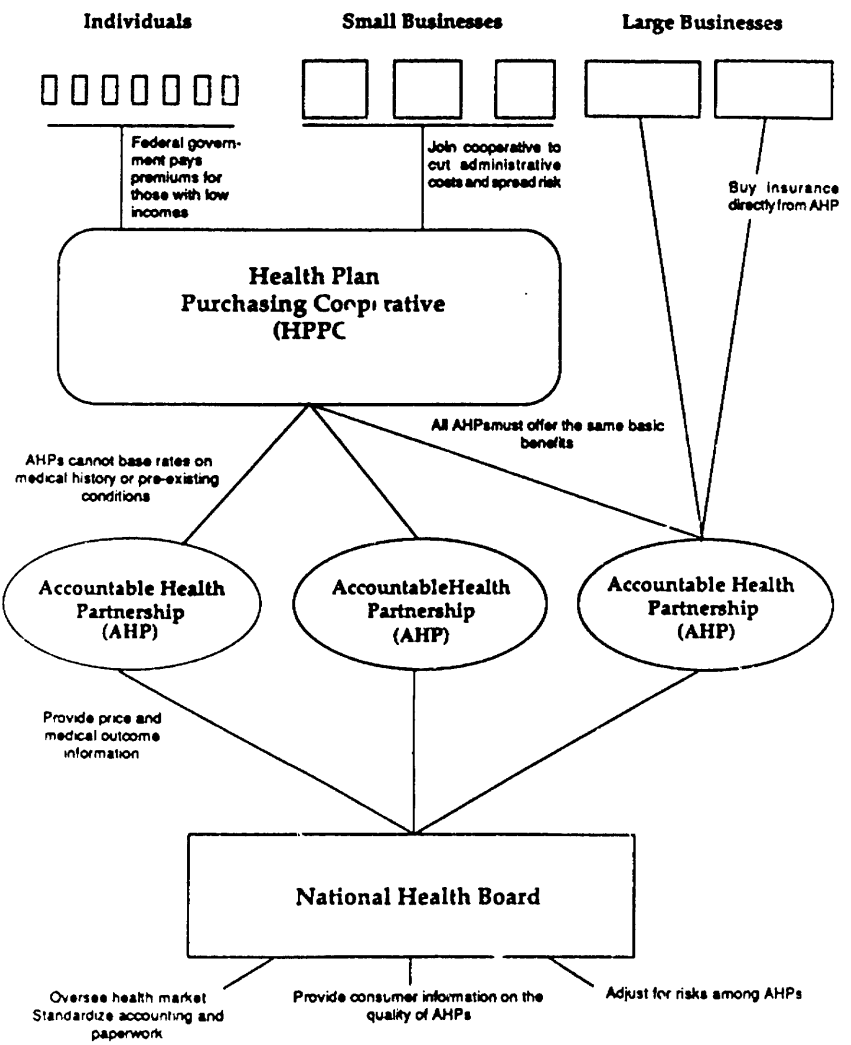
At least $5 billion in annual health care expenditures could be saved by reducing the paperwork required by the nation's 1,500 insurance companies with their multitude of forms.

CDF Proposal: Require all insurance companies to develop standardized and simplified forms. Require the Secretary of HHS to devise a plan to shift to electronic filing of claims and reduce paperwork in Medicare and other federal health programs by at least 5% a year for five years.

Financing

When this proposal is introduced in legislative form this Spring, it will include financing to make it budget-neutral. The new financing is expected to be approximately $50 billion over 5 years.

MANAGED COMPETITION



PREPARED STATEMENT OF LOUIS W. SULLIVAN

INTRODUCTORY REMARKS

Thank you for inviting me to address the important issue of health care reform. I want to share with you the President's commitment to a health care system for the future that attacks cost-driving incentives and ensures affordable access for all Americans. The President is committed to preserving—for all Americans—the best of our world class health care system.

THE PRESIDENT'S COMPREHENSIVE HEALTH CARE REFORM PROGRAM

We are prepared to work with you, Mr. Chairman and members of the Committee, to quickly enact practical reforms that will make a real difference for Americans. The President's Comprehensive Health Reform Program provides effective solutions that address the concerns of all Americans—be they businesses, consumers, or State and local governments. Cost-shifting, inefficient delivery of care, and waste are all tackled head-on in the President's Program.

Soon we will be submitting legislation that would reduce the waste-inducing incentives in the current malpractice system. Yesterday, we delivered legislation that attacks the waste and inefficiency in the paperwork and information handling processes for health care.

If all the cost saving strategies mentioned in the President's Plan were implemented, Americans could see a savings of nearly a trillion dollars by the end of the decade.

Through implementation of a combination of reforms that include revisions in the private insurance and tax systems—and which form the centerpiece of the President's Plan—Americans can quickly gain the benefits from the goals which the President is determined to achieve, including:

- Guaranteed access to health insurance for all poor families through a system of credits with which individuals and families can buy needed coverage;
- Availability of affordable coverage for all Americans and choices that will be of high quality and good value; and
- A rational and stable private system in which individuals can change jobs without fear of losing their coverage due to health conditions, and where individuals don't have to worry about a denial of coverage because of health status.

Additionally, the Plan calls for:

- Modernization of our public Medicaid system;
- Promotion of prevention and the role of personal responsibility;
- Elimination of underlying factors that continue to drive up costs; and
- Elimination of State mandated benefit and anti-coordinated care laws.

The bottom-line message I wish to leave with you today is the President's strong belief that any system of health care reform cannot rely on a centralized, top-down system that stifles choice and innovation.

The President believes an individual's health care involves very personal decisions; consequently, he also believes that the government should not interfere in peoples' choices or treatment options. The government should not restrict opportunities to take advantage of the best health care in the world. If our Nation adopted systems based on either the play or pay concept, price fixing, or national health insurance, the President and I believe diminished quality, restrictions and increased rationing would be the outcome.

The situation *today* in government-controlled systems is decidedly not the outcome Americans are expecting from reform of the American health care system. Let me illustrate:

—In Britain more than one million people are on waiting lists for medical treatment and some wait for more than two years for elective surgery.
—In Canada, under pressure from a global budget, hospital stays are 70 percent longer than in the U.S.—not because the patients are sicker but because the system encourages hospitals not to release recovering patients (especially the elderly) rather than admit expensive-to-treat new patients.
—Canadian doctors, according to a recent report, are deeply concerned about their ability to get access for their patients to special care and medical technology.
—In addition, let me report, a large majority of doctors in Canada and Germany also believe their systems require major overhaul.

The approach to health care reform based on free markets and tax-based incentives proposes a very different role for government: one that helps rather than hinders American citizens and small businesses.

The President offers straightforward solutions to attain his goals through a decentralized, market-based system that is sensitive to individual choice and community needs. These are good, workable solutions for getting Americans affordable health care which do not rely on the top-down, centrally controlled system favored by others such as pay or play or national health insurance.

CONCLUSION

In conclusion, the President's program proposes specific, commonsense measures that target and correct current problems while building on the strengths of the existing system. Eighty-six percent of Americans have coverage; they want affordable coverage that is dependable. The President's plan would achieve this. Those currently without insurance would—under the President's plan—have access to their choice of affordable health insurance and mainstream medicine rather than a government-run—one size fits all—program.

At a time when many American products and services have problems competing in the world's market place our health care system in terms of quality and innovation is second to none. Preserving our world-class system will benefit of all our citizens. Using existing strengths as a building block, we can make corrections that make health insurance available and affordable for our American citizens without bringing more disruption, intrusion and Government waste into our citizens' private lives.

This Administration would be delighted to work actively with Congress to make available to the American people a workable health care plan founded on market-based principles, quality and individual choice.

PREPARED STATEMENT OF KENNETH E. THORPE

Mr. Chairman, members of the Committee, thank you for inviting me to testify and comment on tax-incentive approaches to health care reform. My comments on the potential impact such programs may have will be based on several years of empirical research evaluating similar approaches.

Several reform proposals are currently before the Congress that rely on tax credits or deductions to expand health insurance and control the growth in health care spending. Though I will not provide specific comments on each proposal, or the President's proposal, several common themes emerge. In short, I believe the debate over health care reform focuses on four related questions:

1. Should health insurance be voluntary or compulsory? If compulsory, whose responsibility is it to provide insurance; employers, individuals or the government?
2. What are the new costs of such a plan, and how would these costs be distributed between the public and private sector?
3. How would we finance the government's share of the costs?
4. To control the growth in health spending, should the U.S. rely on market-based, or regulatory controls or both?

The reform proposals you have considered in your deliberations provide substantially different answers to these questions. Those you are considering today, for instance, provide a fundamentally different answer to the first question than more comprehensive efforts to reform health care. In particular, most of the tax-incentive proposals retain a voluntary system of insurance; relying on reductions in the cost of insurance to reduce the number of uninsured.[1] This approach is substantially different than other reform proposals, such as those advanced by the Heritage Foundation, and many economists, that rely on tax-incentives but make insurance compulsory. My comments focus on the former set of proposals.

GENERAL DESCRIPTION OF THE PROPOSALS

The centerpiece of the proposals under discussion today is the provision of tax credits and deductions to assist individuals in purchasing health insurance. The proposals differ with respect to the target population and the extent of the subsidy. For discussion, I use a prototype approach where individuals would receive a refundable credit up to $1200 per year and families are limited to $2,400 per year. This is simi-

[1] Included within the tax-based voluntary proposals are the President's Comprehensive Health Reform Program, S. 454, S. 314, S. 1936, S. 2036 and S. 2095.

lar to the tax credit levels in S. 314 and S. 454, though slightly lower than outlined in the President's proposal. Most proposals relate the value of the subsidy to adjusted income. I assume all families and individuals with annual earnings less than $40,000 are eligible. Cost containment in the proposals rely either on increased cost sharing, managed care, or both.

ISSUES

My remarks will analyze the voluntary tax-incentive proposals along three dimensions:

1. With the refundable tax credits, how many currently uninsured would purchase health insurance?
2. What impact would the tax credits have on those currently insured either through an employer or by direct purchase (i.e. nongroup coverage)?
3. What effect would the proposal have on reducing the growth in health care spending?

I. HOW MANY UNINSURED ARE LIKELY TO USE THE CREDITS AND PURCHASE INSURANCE?

According to the Congressional Budget Office, over 19 million uninsured families (defined per tax law) would be eligible for a tax credit with eligibility limited to $40,000 per year and nearly 20 million at levels outlined by the President. Thus nearly all the uninsured would be eligible for a credit. What the credits will purchase will differ by region, worker occupation, and other factors influencing insurance premiums. For ease of illustration, I compare a typical insurance policy for individuals and families as reported by the Health Insurance Association of America. In 1992 dollars, an individual policy costs $2,100 and family policies typically exceed $5000. The credits would finance 57 of an individual policy and 48 of a family policy.

Two sources of data allow us to estimate the number of uninsured likely to purchase insurance under these conditions; surveys of willingness to pay (which generally produce upper estimates) and actual market behavior. Numerous surveys have asked firm owners and individuals whether they would purchase insurance under different subsidy levels. In one survey, over 75 percent of uninsured single individuals were not sure, or would not purchase any policy even with a 70 percent premium subsidy. Results were quite different for those in families, with the results nearly reversed.

Survey results are notoriously poor predictors of actual behavior; and this appears the case with actually purchasing a health insurance policy. Evaluations I, along with colleagues at Harvard, recently completed examining the willingness of employers and individuals to purchase heavily subsidized health insurance products indicate the survey results likely overestimate actual behavior. For instance, fewer than 16 percent of all firms that currently do not offer benefits are likely to offer insurance even with the insurance premiums heavily subsidized.[2]

We have also recently completed studies in New York State that examine the number of individuals that purchase insurance with even larger subsidies. These pilot projects provided subsidies directed toward individuals at or below 200 percent of poverty. Insurance plans were offered for $7 to $100 per month, depending on actual income and family structure. These premiums represented a subsidy of up to 90 percent, substantially larger than those detailed under the tax credit plans highlighted earlier. Like the proposed tax credits, the value of the subsidy phased-out at higher income levels. Moreover, a substantial investment was made to identify those eligible and market the policies to them; an investment generally not specified in most legislative proposals. The results of the pilot were somewhat underwhelming, fewer than 10 percent of those eligible in the 3 New York State sites actually purchased insurance.

The results from recent experiments which provided similar premium subsidies to those envisioned in the President's plan and other proposals suggest these voluntary approaches will have a limited effect on reducing the number of uninsured. The results from the individual pilot projects in New York indicate that as few as 3 to 4 million would purchase coverage; the employer-based results suggest 5 to 6 million, while 10 million purchasing insurance is suggested by other researchers.[3]

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[2] This is an upper estimate. Only an additional 4 percent of firms actually offered insurance with a 50% subsidy, see Kenneth E. Thorpe, et al. "Reducing the Number of Uninsured by Subsidizing Employment-Based health Insurance", *JAMA* 1992; 267:945–48.

[3] For a survey of this literature, see Howard Chernick, et al. "Tax Policy Toward Health Insurance and the Demand for Medical Services" *Journal of Health Economics* 6 (1) 1987: 1–26.

II. WHAT IMPACT WOULD THE SUBSIDIES HAVE ON FIRMS THAT OFFER HEALTH INSURANCE?

Though each proposal is careful to limit eligibility to those not covered by Medicare or employment-based coverage, substantial incentives for an employer to drop health insurance benefits exist. Of the nearly 90 million workers covered through employer-based insurance, nearly 75 million have annual incomes within the range of subsidies offered under the President's plan. Moreover, the average annual payroll of smaller firms—this includes over 2.6 million establishments with 100 or fewer employees—that offer health insurance is typically less than $25,000 per year. Failure to "lock-in" those establishments that currently offer insurance will dramatically increase the federal costs of these proposals.

The President's subsidy approach is even more problematic. Under his proposed plan, all individuals with annual income (for married couples filing jointly with one or more dependents) at or below $80,000 per year could take a tax credit or a deduction. The deduction allows individuals to deduct the difference between the employer's contribution for health insurance and $3,750. Suppose one could actually purchase a policy at this price, and the employer paid 80 percent of the premium, or $3,000, with the individual paying $750. The employee could deduct the $750, a cash value of $210 for families earning over $35,000 (and only $113 for tower income families). Once employers recognize this relationship, they would have a strong incentive to reduce their contribution by an equivalent amount (here $210), reducing their contribution to $2,790. This allows the employee to deduct $960 ($3750–$2790), a cash value of $269 reducing the effective annual insurance cost to $691. This allows both the employer and employee to reduce the annual cost of health insurance by shifting $221 dollars to the federal taxpayer!

Table 1.— GAMING THE SYSTEM: USING THE TAX DEDUCTION TO SHIFT COSTS TO FEDERAL TAXPAYERS FOR A FAMILY EARNING $80,000 PER YEAR

	Current policy	With adoption of President's plan
Employer Pays	$3000	$2838
Employee pays	750	691
Federal Govt Pays	0	221

*Net of employer contribution and new corporate income tax liability.
**Net of employee contribution and tax subsidy.
Federal figure does not include tax expenditure related to employer-sponsored fringe benefits.

III. WILL THESE PROPOSALS REDUCE THE GROWTH IN HEALTH CARE SPENDING?

The President's proposal, and others currently under consideration in the Finance Committee rely largely on managed care, and increased cost sharing to limit the growth in health care spending. Research evaluating managed care has produced mixed results; the extent of savings depend on the quality of the plan, the potential for savings and plan design. Research evaluating managed care indicates that, relative to conventional plans, savings could range from 0 percent to 20 percent; with 10 percent a mid-point estimate.[4]

More aggressive, market-based approaches would change the federal tax law, treating employer-sponsored contributions as taxable income. This, according to theory, would make consumers more cost conscious, resulting in increased deductibles, copays, fewer benefits insured, and active choice. Even if all the above had occurred during the past 30 years, results from the largest health insurance experiment ever conducted, by Rand, indicate that the such approaches would have limited effects. Between 1950 and the mid-1980's, inflation adjusted spending on health care increased 7 fold. Implementing the aggressive increases in cost sharing and "price" consciousness would, according to the Rand results, have reduced this growth by less than 10 percent.[5]

Though competition is desirable it will not, by itself, reduce the growth in health spending. One approach is to mix competition with an all-payer rate setting ap-

[4] Point of service plans are one such "successful" approach, see Ron Goetzel, Kenneth E. Thorpe, J. Fielding and K. Pelletier, "Behind the Scenes of a POS Program", Health Care Benefits, March/April 1992:33–37. This state of the art plan generated a 13 percent reduction in spending.

[5] Willard G. Manning, et al. "Health Insurance and the Demand for Medical Care" *American Economic Review* June 1987:251–277.

proach as Massachusetts experimented with during the mid-1980's. Alternatively, one could examine the results from New York State, and Rochester, New York where all payer rate setting (with less competition) was used. The results from these experiments are clear, and in each case health spending relative to gross state product outperformed the remaining states and Canada (see Figures 1 and 2).

IV. CONCLUSION

In sum, voluntary tax credits will allow some individuals to purchase insurance. They are likely to have a minor impact on reducing the number of uninsured, and appear ill-equipped to address the growth in health care spending. Moreover, tax credits in a voluntary system have a fundamental flaw: larger credits will result in fewer uninsured and larger disruptions of existing private insurance. Smaller credits are even less effective in reducing the uninsured. The former is not particularly target efficient, and increases federal costs, and the latter approach results in a small reduction in the uninsured. What seems clear is the consensus developed among potential reformers of the health system as diverse as Alain Enthoven, and proponents of the Canadian system point in one direction: addressing the underlying issues of cost growth and the uninsured requires the adoption of a universal health insurance system.

FIGURE 1.

Hospital Spending As Percent of State Product, 1980-1986

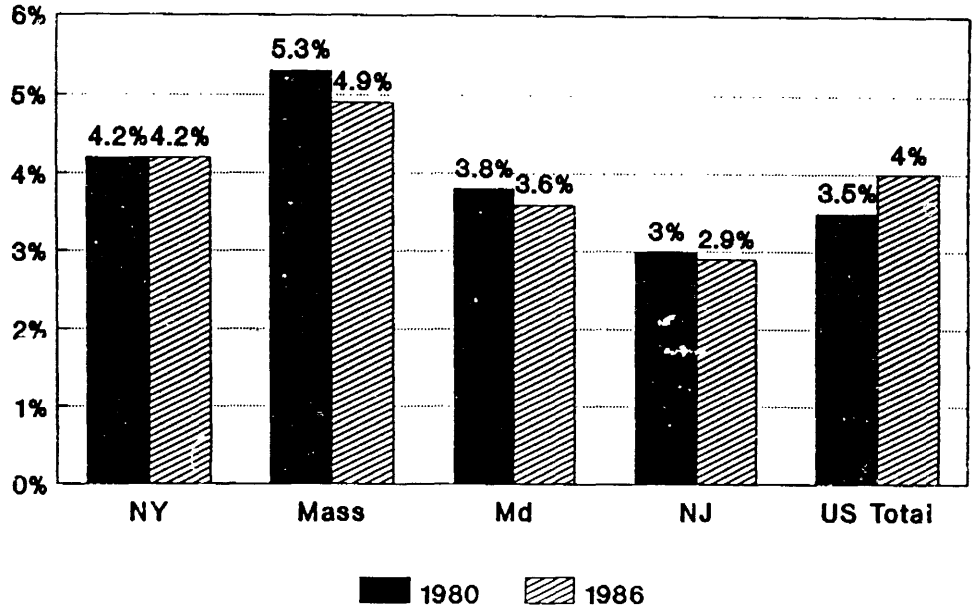
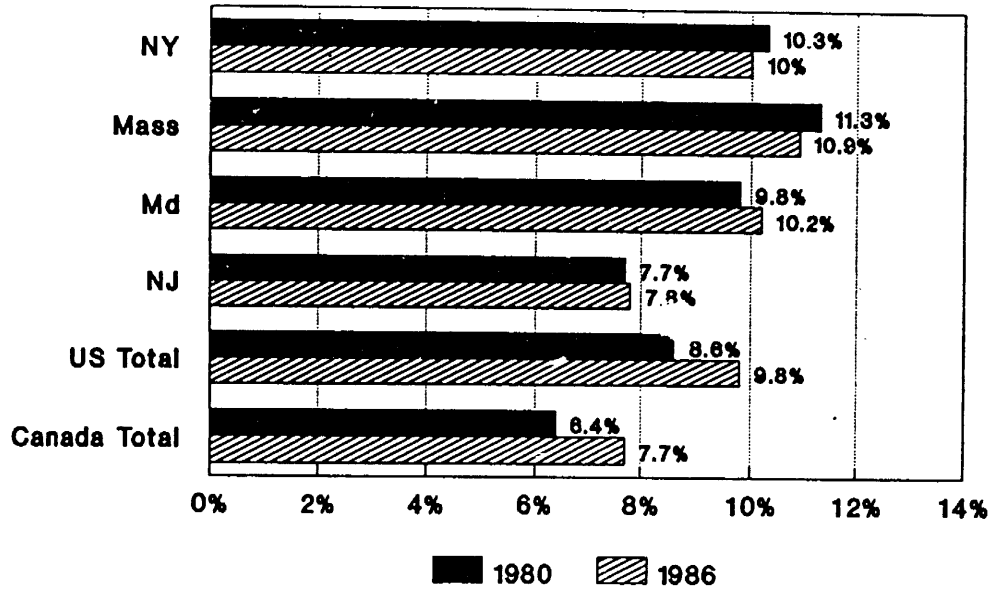


FIGURE 2.

Personal Health Spending As Percent of State Product, 1980-1986



PREPARED STATEMENT OF BERNARD R. TRESNOWSKI

Mr. Chairman, Members of the Committee:

Most of the people in this room today, and most respected observers of the health care system, would agree that we are on the brink of a medical meltdown.

We all know the grim statistics:

- More than 35 million Americans have no health insurance.
- Health care expenditures are inching toward $1 trillion and 15 percent of gross national product.
- And we know all too well that a $1 trillion health care tab simply will not wash in a faltering economy in which many worthy needs vie for scarce dollars.

These facts all lead to the same conclusion: health care is becoming less affordable and less available, and unless we do a better job controlling costs, any attempt to broaden access is doomed to failure.

But I would submit today, Mr. Chairman, that we need not be resigned to failure. We can make a commitment to meaningful reform of our health care delivery and financing systems. We can preserve the best of our current system but make it more accountable and responsive to health care consumers. We can do this by expanding employment-based health insurance coverage. We can do it with approaches tailored to the communities where people live. We can do it through partnerships among everyone involved in health care. It would be a new way of doing business, but it would work.

Mr. Chairman, the Blue Cross and Blue Shield Association believes that the health care status quo no longer is acceptable. We advocate reform of the health care financing and delivery systems. We recognize the need to alter the way health care is financed and delivered in this country. And we acknowledge that insurers need to clean up their own act if health care costs are to be controlled and access to care broadened.

The focus of this hearing is expanding employment-based health insurance coverage. Expanding access to health care through broader insurance coverage is a commonly held goal that so far has met with only limited success. The reason is clear: access costs money, and there is precious little to spend. Today I would like to talk about how costs can be controlled and access broadened in the context of the Blue Cross and Blue Shield Association's proposal for health care reform, "Community Partnerships for a Healthy America."

Our Association's proposal would go a long way toward reconciling the cost/access dilemma. We recognize that, in today's budget climate, to broaden access to care we must rein in out-of-control costs and make health care benefits more affordable. Our proposal does this by building strong incentives for value and economy into the delivery and financing of care.

BUILDING ON WHAT WORKS: PRIVATE, EMPLOYMENT-BASED HEALTH INSURANCE

The Blue Cross and Blue Shield Association's health care reform initiative begins in the workplace, where the vast majority of Americans already receive health insurance protection. Employer-based, private-sector coverage is the logical vehicle to extend health insurance to as many Americans as possible. An estimated 85 percent of the 160 million people with private health insurance are covered by their employers, while nearly 80 percent of the more than 35 million Americans lacking insurance coverage are full- or part-time workers or their dependents.

Another important reason for building on private insurance provided through the workplace is that most people like their employer-based insurance. However, many worry about losing those benefits in the future. Employers that offer health insurance are buffeted by annual cost increases that reflect the rapid increase in medical care costs. These increases chip away at profit margins, forcing many employers to trim or eliminate coverage. Workers with health insurance watch their contributions rise, their deductibles and co-payments increase and their benefits shrink. Countless employees suffer "job lock," forced to keep jobs that no longer satisfy them in fear that a move would leave them uncovered for a pre-existing ailment or with no health insurance at all. Worse, a seemingly stable job, and the health insurance that comes with it, can disappear overnight, as often has happened during the recent recession.

Reform of the system to make coverage both universal and portable between jobs can be accomplished without the excessive tax increases or the government bureaucracy that would be needed for a single-payer system. It can be accomplished with employer-based private insurance that provides flexibility for adding or changing benefits to meet the needs of individual employees rather than having benefits determined by the political process. Private insurance is responsive to public needs.

We believe our proposal for reform constitutes a thoughtful, innovative alternative to the two basic strategies for employer-based coverage: an across-the-board employer mandate and a "play-or-pay" strategy, the most common plan to broaden access through the workplace.

We see a key, severe flaw to both these approaches: they make unrealistic assumptions about how much small employers can afford to contribute to health benefit costs. To ask small employers that are not now contributing to employee health care costs either to assume the full costs of those benefits or to pay as much as a 9 percent payroll tax would significantly burden the segment of our economy on which we rely most heavily for new job creation.

We see further problems with the play-or-pay model, one being that it would evolve into a single government-funded and -operated national health program. This approach has inherent in it a significant incentive for employers to drop employment-based health insurance and instead pay the payroll tax penalty. For such a tax to be politically acceptable, it may have to be set below the actual cost of providing benefits. Employers then would find it less costly to send their employees to the public pool than to provide benefits directly. If too many employers exercised that option, a massive government-run program, with all its disadvantages, would evolve.

We also fear that the centralized system that could result from the play-or-pay approach would diminish responsiveness to individual health care needs of employers and employees. No longer could employers and employees negotiate to determine the most appropriate benefit package. Nor would the accountability and responsiveness of the employer-managed system be retained, especially with regard to individual employee problems. Instead, all employees would be forced to work through an elaborate bureaucracy.

Finally, play or pay depends on price controls and regulations that are incompatible with effective cost containment. Setting arbitrary limits on how much is spent on health care or on the cost of a particular service fails to address the need to manage the use of health care services. Costs cannot be contained unless there are incentives for individuals to change the way they use the health care system and for providers to change the way they practice medicine.

The Blue Cross and Blue Shield Association alternative addresses these issues. It blends an employer-based coverage mechanism with government subsidies to expand access for working and non-working Americans alike. Instead of public insurance pools to cover employees whose employers do not contribute to coverage, our proposal relies on the private insurance market for employment-based coverage.

Our proposal recognizes that we cannot treat large and small employers the same way. Just as most of them do now, large employers would be required under our plan to contribute to their employees' coverage for basic benefits. Employees would be required to accept the coverage, and those at or below poverty would be subsidized for their share of the premium. Subsidies would be available on a sliding scale for workers above poverty level.

Small employers would have two choices. First, they could contribute, just as large employers do, to the cost of the premium for basic benefits. Employees would be required to pay the balance of the premium, with low-Income workers subsidized for these costs. Alternatively, small employers could decide only to offer private coverage for the basic benefits. They then would contract with a private insurer and make payroll deductions but would not contribute directly to the cost of the coverage. Employees of small employers would be required to accept the coverage, but everyone would receive a subsidy of at least 40 percent of the premium. Employers that only offer—and do not contribute to—coverage would pay an assessment of approximately 3 percent of payroll to help offset the cost of this 40 percent subsidy. Those with low incomes would be subsidized on a sliding scale; those below poverty would be fully subsidized.

All workers would be covered in their employment setting under private insurance. Even those employees whose employers do not contribute directly to the cost of coverage would receive affordable private group health insurance. There would be no need for a public pool.

Non-workers would be required to purchase the basic coverage. Everyone, regardless of income, would be subsidized for 40 percent of the cost of the basic benefit package. Additional subsidies would be available for low-income families. Non-workers at or below poverty level would be covered under an expanded Medicaid program but would have the option of purchasing private coverage on a subsidized basis. Mr. Chairman, we believe the approach outlined above is the most viable proposal for expanding access to health insurance through the workplace. It is a compromise that avoids extreme solutions and unacceptable alternatives. This proposal is a rea-

sonable option for consensus between those who favor employer mandates and those who would opt for a government-operated health care system.

BEYOND MANAGED CARE

The Blue Cross and Blue Shield Association believes that universal access to health care hinges on health care cost containment. We further believe that the only viable avenue to cost control is to establish a system that encourages better medical practice and health care delivery systems that are more efficient and responsive to community health care needs. This approach relies on reforming and continuously improving delivery systems in every community.

Our health care reform proposal, Community Partnerships for a Healthy America, is the culmination of more than 60 years experience with local health care delivery systems throughout the country, 10 years experience as the country's largest managed care organization, and two years of work to frame a national health care reform proposal.

Our experience indicates that the techniques collectively known as managed care can make health care more affordable. But managed care operating in the current health care financing market is still a long way from offering an effective cost-containment strategy. We must move into a new generation of managed, care. Just as management techniques have been sharpened in other sectors of our economy, similar improvements must be achieved in health care financing and delivery. I have not come here today as a defender of the status quo, to ask you to leave things alone. We need to apply an aggressive, comprehensive health care reform strategy based on the promising beginnings we see in managed care. We have to rebuild the current system from the ground up.

To progress from managed care as we know it today to an effective cost-containment policy, health care reform must address four challenges:

1. *First, we must change the nature of competition among carriers in the private health care financing market. Competition should be based on cost-effectiveness and quality of service, rather than on ability to select the best risks*

The simple truth is that in today's health insurance market the easiest way to lower your premiums and increase your profits is by avoiding or disenrolling people with expensive health care needs. It is much more difficult to achieve the same result by selecting the best providers, giving them the best incentives and information, and organizing them into the most efficient group practices. Trying to promote cost-effective care in this environment is like trying to teach kids in a school where flagrant cheating is allowed and accepted.

Our health care reform proposal would address this problem by changing the rules of competition. We call for federal standards, enforced by states, for all entities that sell health benefits coverage. We call these entities "Accountable Health Plans." The reforms we suggest would prevent carriers from competing to avoid risk. Those counterproductive energies would be rechanneled into competition to achieve economies without sacrificing quality. We also would make the offering of an acceptable managed care program a condition of being in the health insurance business. Over time, every health insurer would have to move an increasing portion of its membership into approved managed care networks, or "Community Care Partnerships," to retain its license to market insurance.

Any insurer unable or unwilling to meet these new requirements would not be allowed in the marketplace. We believe that this combination of market practice reform and managed care enrollment requirements would dramatically increase the intensity and quality of managed care activity in the market.

2. *Second, we must provide employers and individuals with stronger incentives to enroll in Community Care Partnerships*

We see this as a matter of supporting and accelerating a trend already underway. Left on its own, the marketplace is moving to managed care networks, but it would move more quickly with additional incentives.

That movement need not take place at the expense of customer satisfaction or choice of provider. Our public opinion polling indicates a large majority of support (75 percent) for health care reform that includes incentives to use managed care networks of physicians and hospitals with a record of providing high-quality, cost effective care. This support is reflected in the increased movement already underway to managed care networks. Ninety-two percent to 96 percent of Blue Cross and Blue Shield managed care members are satisfied with the quality of their medical care. More than 80 percent are satisfied with their access to care, choice of physicians and waiting times. These results are comparable to or better than those for traditional health benefit programs.

With growing acceptance of managed care by employers and members, it is time to create strong incentives for all employers to enroll their employees in managed care networks. To do this we would make the employer deduction for employee health benefit payments increasingly contingent on enrollment of employees in a Community Care Partnership.

3. Third, we need to promote greater accountability of insurers for meeting community health care needs

In discussing health insurer requirements and employer incentives, I referred to Accountable Health Plans. We propose that states would certify these Plans based on federal standards. We believe it is essential that there be non-prescriptive national standards defining the important elements of Accountable Health Plans. However, we believe that states should be responsible for interpreting these standards.

Federal standards would define an Accountable Health Plan as an entity that: provides a full range of basic benefits; provides services under selective provider contracts that protect patients from balance billing; has or arranges for a program that profiles provider practice patterns; has or arranges for certified programs for utilization review and quality assurance; and has or arranges for a program to monitor and improve enrollee health.

Accountable Health Plans should be responsible not just for delivering cost-effective health care, but also for developing initiatives to improve enrollee health. It will be particularly important to allow states and Accountable Health Plans to experiment with new approaches rather than mandating adherence to a specific set of activities.

With this new accountability structure in place, we would also propose that all state "anti-managed care" laws be overridden for approved Accountable Health Plans.

4. Fourth, we need to disseminate information about the best health care delivery system practices

The forms and techniques of managed care are evolving rapidly. There is a tremendous amount of work underway to develop new ways to deliver health care, more effective incentives for health care providers, and better methods of evaluating medical practice and giving physicians the information they need to improve it.

Under our proposal, Accountable Health Plans, insurers, employers, state and federal regulators and Congress all would have a stake in finding the most effective ways for organizing and improving health care delivery. Network managers and insurers would apply information to improve their performance. Regulators and Congress would ensure that federal standards and state application of these standards promote the highest quality, most cost-effective health care networks and afford network managers appropriate latitude to experiment.

We propose that a national health reform proposal include the designation of a national organization, dedicated to studying managed care and health care delivery system practices, and reporting to Congress, regulators and the market on the most effective practices. This research would help to assure that insurers, employers and health care providers are aware of the most innovative and effective managed care strategies.

CREATING A COST-MANAGEMENT INFRASTRUCTURE

In conclusion, Mr. Chairman, we face an historic, strategic choice that will affect the character of our health care delivery system for decades to come. We are all tired of unrelenting health care cost-increases that infringe on access to care for far too many Americans. And it is tempting to try to deal with the problem once and for all with a supposedly guaranteed solution.

But we are not going to deal with the problem once and for all. It will be with us for the foreseeable future. It will be with us be-cause we will continue to seek ways to prolong life by finding more expensive ways to treat health care problems.

The question for this committee is not how to solve the access dilemma by getting rid of the health care cost problem. The question is how to balance access and cost 10, 20, 30 years from now in a way that best promotes health and delivers the most value to the citizens of this country.

To do that, we need a health care cost-management infrastructure in this country—one that will change fundamentally the incentives for providing and financing health care services. These changes are beginning to emerge in communities around the country. We urge you to take action to nurture them, make them more accountable and help them to be more effective.

The Blue Cross and Blue Shield Association is committed to developing an infrastructure that will enable us to deliver the best health care we can afford to every citizen. We look forward to working with the committee on this important issue.

RESPONSES OF MR. TRESNOWSKI TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question No. 1. Under your plan, you have a play or pay option for small businesses with the pay option requiring a 3% payroll tax to subsidize employees premiums. Explain why you believe 3% is the appropriate payroll tax for the pay option. Don't you find this low tax rate an incentive for all small businesses to choose the pay opion? Will the 40% subsidy for employee premiums be completely funded with the 3% payroll tax?

Answer. Small Employer Payroll Tax Option. You questioned why we chose 3 percent as the payroll tax level for small employers that do not contribute to their employees' coverage. We distinguish between responsibilities for large and small employers in our proposal to recognize the special affordability problems faced by some small employers. We tried to settle on an amount that would be affordable for most small employers, while still requiring them to contribute in a significant way to the health care costs of their employees.

According to our initial analysis, the 3 percent payroll tax would generate enough revenue to finance the 40 percent subsidy for employees of employers that only offer coverage. (This compares to the 80 percent subsidy that would be required of large employers.) However, as with all numbers used in the health care reform debate, the payroll tax level necessary to support the subsidy over time is subject to change.

We believe that small employers already offering coverage and contributing to the costs of that coverage will continue to do so. Small employers that do not currently offer coverage may very well opt for paying the 3 percent tax instead of financing 80 percent of their employees' coverage (as required under our proposal). Their employees would use the 40 percent subsidy (with additional subsidies available for the low-income) to purchase private coverage.

Question No. 2. Do you believe the "encouragement" of managed care is a strong enough cost containment measure?

Answer. Cost Containment. You asked whether "encouraging" managed care is a strong enough cost containment measure. The answer is no. But our proposal goes considerably beyond "encouraging" managed care.

The first and most important element of our cost containment strategy is eliminating insurers' ability to compete based on risk selection. Risk selection currently is the most powerful cost containment tool available to insurers—they can hold down costs much more easily by screening out high risks than by trying to manage overall health care costs.

Under our proposal, insurers no longer could use risk selection to maintain competitive prices. Instead, they would have to compete on the basis of their ability to manage costs. Our cost containment strategy would further this goal by channeling more and more of the marketplace into advanced managed care networks—we call them Community Care Partnerships—networks of high-quality, cost-effective providers who would manage the overall care of their patients. We would require both insurers and employers to enroll increasing percentage of their enrollees/employees into these CCPs over time. For insurers, we would make it a condition of qualification as an Accountable Health Plans, and for employers, we would make it a condition of the tax-favored treatment of their health care expenditures.

Question No. 3. What is your opinion on small businesses pooling this employee risks and their purchasing power to buy health insurance? Does this option fit in under your proposal.

Answer. Small Employer Pooling. Finally, you asked our opinion on pooling of small employers' purchasing power to buy health insurance. We support many of the goals of purchasing group proposals, but we believe many of their objectives can be met through the types of reforms recommended in the Blue Cross and Blue Shield Association's health care reform proposal. Our proposal would extend insurance market reforms across all insurance markets, not just the small group market. In addition, the market reforms we recommend would result in a reduced number of carriers (because carriers that did not want to or could not meet the requirements would exit the market). This would result in greater pooling of risk among remaining carriers. Our proposal also would achieve the objective of reduced administrative costs, through our requirements in that area.

Through these and other reforms, our proposal would result in a more responsive and more streamlined health care market—one that would better meet the needs of small employers. While it may be useful to experiment with health insurance purchasing groups to meet these same objectives, given the untested nature of these

arrangements, and the high degree of market disruption they would cause, moving forward with such proposals on a wide-scale basis would be a very high-risk strategy.

PREPARED STATEMENT OF SENATOR PAUL D. WELLSTONE

Mr. Chair, thank you for the opportunity to address you and the Committee today on the need for a single payer health care system.

Let me first say that the challenge before us now in the Senate is to move beyond discussing health care as a problem, to developing sound public policy that will make a difference in the lives of people.

I start with the proposition that our health care system is in a state of crisis.

I have learned this from my own experiences with family, with friends, with loved ones. I have learned this as I traveled across Minnesota in my campaign for the Senate, as over and over again people impressed upon me how the system is failing in oh so many ways. I learn this virtually every day as a Senator as I speak with people from across Minnesota, as I read their letters, as I meet with health care providers, as I attend Senate hearings.

And if our health care system is in crisis, then what follows is that we need to reform our medical system, we need change.

And I believe nothing short of fundamental reform will do.

Any reform must address the two underpinnings of our crisis: the crisis of access and the crisis of cost. That is, millions upon millions of Americans without any insurance or with too little insurance, and health care costs skyrocketing out of control.

We must solve our crisis of access and our crisis of cost simultaneously.

And our goal must be this: Every citizen deserves access to affordable, quality health care—regardless of income, regardless of employment status, regardless of current health condition, regardless of age.

Let's compare this goal to our present realities:

There are now more uninsured Americans than at any time since the creation of Medicare and Medicaid in 1965, and millions more, increasingly the middle class, with too little insurance.

The United States is the only major industrialized country other than South Africa which fails to guarantee all of its citizens access to medical care—a reality, a disgraceful reality.

A quarter of our health dollar is spent on billing and administration, instead of on the actual care of people in need. And the number of health administrators is rising three times as fast as the number of physicians or other health workers.

The United States spends more on health care than any other nation, more than 13 percent of our gross national product. We are projected, on current course, to be spending 17 percent of our GNP on health care costs by the year 2000 and 37 percent by the year 2030. This we cannot let become a reality.

Health care expenditures amounted to over 100 percent of after-tax business profits in 1991.

We have the most expensive health care system in the world, yet the least comprehensive and the least popular among developed countries.

It is the most expensive, and the most confusing and bewildering for consumers—for physicians and other health care providers.

Today there are more than 1,500 private health insurance companies. In large part, they compete based on risk selection—that is, insuring only the healthiest individuals they can find—instead of competing on efficiency or service.

We have let a private industry, the private insurance industry, write the rules, make the decisions about who gets insurance and who must go without.

And what has the insurance industry decided about who gets care and who does not? The industry has decided that it will seek to maximize its profits by insuring only well people. People who are most in need of medical care frequently cannot get health insurance.

This turns the very concept of insurance on its head. You can only get insurance when you can demonstrate that you won't need it.

This isn't to say that all insurance companies have bad intent. But insurance companies are operating in a system with perverse incentives.

It will be these realities that will make health care reform a reality. Because the reality is, we have no other choice.

It is time to make sense out of the system.

I believe we need fundamental reform, a complete overhaul of a health care system that is too costly, too arbitrary, too unfair.

The single payer system I have proposed in S. 2320 is the simplest, fairest, and most effective route to comprehensive, quality, affordable health care for every American.

The huge advantage of the single payer system begins with cost control. It would streamline and simplify the administration of health care, while preserving and enhancing consumer choice in the delivery of health care.

Services would still be delivered by private hospitals, HMO's, doctors, and other health care professionals.

The system would also save money by emphasizing primary and preventive health care, that is less costly and more effective than the kind of wasteful and unnecessary specialized services we see so much of today, largely because it is the kind of care health insurance plans now cover.

Every other industrialized country in the world has expanded access and controlled costs, more effectively than we do, by using some kind of concentrated public authority. There simply is no other match in negotiating with the pharmaceutical drug industry, the hospital supply industry, and, in the case of the U.S., the insurance industry.

Whether they are single payer systems or multiple payer systems, the public sector plays the lead role in setting costs and benefits. This means the health care system can establish national health expenditure budgets and global operating budgets that really do control costs.

Capital costs for health care would be budgeted on a state-wide basis. This would allow for a rational and controlled system of decision-making instead of the current system, which has been accurately described as a "medical arms race."

Government is already heavily involved in the health care system. But under the current system, decisions are made, rules are written, in the context of a fundamentally flawed health care structure.

For example, the rules and regulations for Medicaid and Medicare are too complex. That's in large part because of we are struggling to fit these programs into our current complex patchwork of health insurance programs. And it's also because cost pressures are now forcing bottom-line decisions since there is no overall framework to get control of skyrocketing health care costs.

The single payer system I am proposing is the least intrusive and the most effective. It lets the government do what it does best. It collects the funds and sets the broad guidelines for a fair and comprehensive system. It leaves administration at the state and local levels.

Private doctors, mid-level professionals, hospitals and clinics would operate just as they do today, except that they would be able to return to the business of caring for patients based on what they need. They would get out of the business of deciding who gets what care based on ability to pay, and get out of the business of bureaucratic administration.

And this system also builds in a structure of accountability to the public.

In large measure, the cost of a national health insurance program could be borne by the savings gained from administrative efficiencies and other cost control measures.

In fact, a report released last year spring by the General Accounting Office found that adoption of a single payer system like Canada's in the United States would save an estimated $67 billion a year in administrative costs, far more than necessary to pay for insurance for all uninsured Americans.

Another study published by the New England Journal of Medicine found that we could save even more money if were as efficient as Canada in administering our health care system, perhaps more than $100 billion a year.

My proposal eliminates cost-sharing. Cost-sharing discourages utilization of both needed and unneeded care by those who can't afford it, with possible harm to low-income populations. And there would be additional costs for administration of co-payments. Most importantly, there is overwhelming evidence that it does nothing to control expenditures, which are primarily provider driven. Though low-income patients may stay away, providers have learned to fill their practices with patients who can afford to pay. Health insurance plans in the United States have increased individuals premiums, co-payments and deductibles dramatically in the last decade, with no success in holding down costs. Utilization of services has not grown appreciably in the last decade, and in hospitals it has declined. But increased provider charges have been the major cause for health care inflation. It is exactly this kind of unbridled excess that my proposal would control.

Preliminary reports from studies of U.S. populations that went from no coverage to coverage for health care suggest that including the uninsured in a national health care system will not increase costs significantly. In fact, universal coverage, and comprehensive benefits, are key to cost control in systems from the state of Hawaii

to the nations of Europe. We would end cost shifting, from uninsured to insured, from uninsured long term care services to insured hospital services.

I firmly believe that it will be the potential for cost control and cost savings which will drive the health care debate and drive health care reform.

And it is this potential for cost savings which is in large part responsible for the growing support—inside and outside Washington—for a single payer system.

It is this cost saving potential which has the ability to bring together unusual coalitions in support of a single payer system. This is not a liberal issue or a conservative issue. This is not a Democratic issue or a Republican issue. This is not a business issue or a labor issue or a consumer issue.

A national health insurance program is certainly in the best interest of consumers of health care.

And I wholeheartedly believe that it is also in the best interest of health care providers. Our present health care system is filled with too much paperwork and too much bureaucracy. Practicing medicine has become more and more of a hassle.

The situation has become so bad that a recent Gallup poll showed almost 40 percent of physicians in the United States probably would not go to medical school if they had to do it all over again.

But a national health insurance program would streamline our health care system. Providers would be able to spend more time on patient care and less time on billing and bureaucracy.

And what will be the cost of a national health care system?

The most realistic answer to this question is that we can achieve universal access through a national health care system for the same level of spending as today.

The money will be spent in different ways from today. We will save money in administrative costs, and plow that money back into medical care.

And the money will be raised in different ways from today. There will be no more spending for insurance premiums for covered benefits. There will be no more out-of-pocket spending. Instead, we will be publicly financing the system.

Yes, I'm talking about raising taxes to finance the system. But these new taxes will be offset by reduced private spending for health insurance. And these taxes will be dedicated to a national health trust fund to insure that these taxes are spent on health care, and only on health care.

Look at it this way. Say right now I'm an individual, maybe a farmer, who is spending $1 for private health insurance. One dollar out of my right pocket. Under a national health insurance system, I wouldn't spend that $1 from my right pocket. Instead, I'd be spending $1 from my left pocket, in taxes.

Or let's say I'm a business owner. Right now I'm spending $1 for health insurance for myself and my employees. Under a national health insurance program, the same scenario. I keep the dollar in my left pocket, but I am taxed the dollar in my right pocket.

So higher taxes, but no higher spending for health care. In fact, for 95 percent of Americans, it will be less spending. Our figures show that an average family of four will spend $1,620 less each year in taxes than they currently spend out of pocket for health care services, insurance premiums, co-payments and deductibles.

In S. 2320, the national health expenditure will be set at the level of spending for the year preceding implementation of the national health care system. This is very achievable.

The GAO report that I mentioned earlier estimated that we would save $67 billion in administrative costs in the first year of a single payer system. The GAO also found that it would cost about $64 billion in additional spending to pay for insuring the uninsured and providing additional services to those currently with insurance. So there would be a net savings nationwide of about $3 billion.

A more recent study by the CBO, using some different assumptions from GAO, found that we would have a net savings of $26 billion dollars under a single payer system. In other words, taking into account both the increased savings from administrative costs and increased spending to cover the uninsured and underinsured, we would save $26 billion a year.

Over time, our savings would be even more dramatic—because the system will provide us with a mechanism for drastically reducing the rate of increase for health care spending. In part, this is accomplished by providing that health care spending will be allowed to increase only as much as the annual percentage increase in GNP.

A national health insurance program can live up to its billing. This is a program that can work.

It does work for our neighbor to the north, Canada. We need to study the Canadian example, learn from its successes and failures and use American innovation and technology to establish the finest—and most efficient and equitable—health system.

No one is saying we should adopt the Canadian system wholesale in the United States. We must preserve the strengths of our health care system—our HMO plans, our centers of excellence like the Mayo Clinic, our technological advances. We will preserve the diversity of private health care settings and health care practitioners.

There have been some scare stories about the Canadian system. Recently the health insurance industry, which stands to lose the most from comprehensive health care reform, has financed an ad campaign promoting these stories. To put it mildly, these stories have been greatly exaggerated.

The truth is polls show Canadians to be more satisfied with their health care system than citizens in any other country—and Americans are the least satisfied.

What about the issue of rationing?

The truth is the United States already rations health care—in "irrational ways," according to the Journal of the American Medical Association. At present, we ration health care by ability to pay, by health status, and by employment status. People who cannot afford health insurance do not get the same health care as others. People who need health care the most because of serious illness are blacklisted; they cannot get private health insurance because of pre-existing conditions. And people who are self-employed or who work for or own small businesses or who are unemployed are often unable to get insurance.

At $800 billion a year, there are more than enough resources to provide every citizen the health care they need, without delay. A national health insurance program would grant them equal access to that care. Medical care would depend on a professional assessment of medical need rather than on insurance status. And the national health insurance program would give us the framework for reasoned planning and decision-making about how to invest and spend our health care dollars.

What about physician satisfaction under a national health insurance program?

In Canada, there are more than double the number of applicants for each medical school spot than in the United States. The number of physicians leaving Canada dropped dramatically to only 386 in 1985. And a recent survey in Canada found two-thirds of doctors describing themselves as satisfied or well-satisfied.

Polls in the United States consistently show support for the proposition that health care is a right and support for a national health insurance program. Polls also show that Americans are willing to pay more in taxes for a more fair and equitable system.

We must listen to these voices. We must decide whether there will be democracy for the few, or democracy for the many. We must work together to make reform a reality. The vast majority of the people are calling for nothing less.

COMMUNICATIONS

STATEMENT OF THE AMERICAN BAR ASSOCIATION

Mr. Chairman and Members of the Committee: I appreciate the opportunity to present the views of the American Bar Association on medical professional liability in the context of proposals to increase access to health care. am Ronald Mallen, a member of the ABA's Special Committee on Medical Professional Liability.

Since 1972, the ABA has been on record in support of legislation that would provide for every American to have access to quality health care regardless of a person's income. In February 1990, the ABA's House of Delegates reaffirmed its support of such legislation and recommended that any such legislation should include the following characteristics:

1. Universal coverage for all through a common public or public/private mechanism through which all contribute;
2. A single payer system to facilitate expenditure control;
3. Appropriate containment of administrative and health care costs, and of administrative burdens on employers;
4. Mechanisms to assure the quality and appropriateness of care; and
5. Freedom of choice, procedural due process, and administrative simplicity for consumers.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation, and a concept the American Bar Association supports. Likewise, access to the American legal system has been a fundamental right tracing back to the origins of this country.

The ABA understands the concerns being expressed about the issue of medical professional liability and is deeply committed to having a legal system in America that is effective and just, one that protects the rights of plaintiffs and defendants. Two ABA entities worked towards this end by developing recommendations for the ABA's House of Delegates. They are the Special Committee on Medical Professional Liability and the Action Commission to Improve the Tort Liability System.

The ABA Special Committee on Medical Professional Liability was composed of a balanced group of plaintiffs' lawyers, defense lawyers and representatives of academia, and the judiciary. The Committee was chaired by our current ABA President Talbot S. D'Alemberte, then Dean of the Florida State University College of Law. The Committee was charged with studying legislative initiatives in the medical malpractice area and developing ABA policy proposals for the Association's policymakers to consider. In February 1986, the ABA House of Delegates adopted a resolution at the recommendation of the Committee. (A copy of that resolution is appended to this statement as Appendix A.) The Committee was then disbanded, however, it was reactivated this past August.

Near the end of 1985 the ABA, through its President, appointed an Action Commission to Improve the Tort Liability System. The 14-member Commission was asked to develop specific proposals to improve the tort liability system. The members of the Commission were federal trial and appellate court judges; a state Supreme Court justice; corporate counsel, including those with insurance experience; consumer and civil rights advocates; academicians; and practicing plaintiffs' and defense lawyers.

In February 1987, the ABA House of Delegates considered the Commission's recommendations and adopted the resolution appended to this statement as Appendix B. The ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state, and not the federal level.

Our ABA policies reflect the ABA's recognition that the issue is of vital importance not only to the legal profession but to the medical profession, the insurance industry and, most of all, to the public.

The public has the most at stake in this issue. When a person suffers injury as a result of negligence by health care services, he or she must have the right to seek recovery for the full measure of those damages. We believe that right is severely threatened by those who call for major changes in this country's tort law system, and particularly by those who propose that limits be placed on the amount of damages persons may seek in compensation for their injuries caused by the negligence, or carelessness of health care providers.

We are particularly concerned with proposals to alter the system of medical malpractice to carve out exceptions in the tort law system for one group of potential defendants—in this case, doctors and other medical professionals. It is the ABA's belief that the rights of injured persons to recover fully for injuries caused by the wrongful acts of others must be protected. We are concerned that those who seek major changes in the way the tort law system deals with cases of medical malpractice are willing to trade away the rights of all individuals in the hope of easing a perceived burden on some or reducing the overall costs of health care. Since medical malpractice insurance costs make up only a small fraction of the dollars spent on health care in the United States, the changes in the tort laws would have no real impact on costs of health care.

In addressing access to health care proposals, that contain provisions on medical professional liability, three questions need to be asked. First, what is the cost savings that can be achieved? Second, have such provisions, when enacted, lowered health care costs in states which have adopted their essential elements? Third, what are the consequences to the traditional American legal system and to the rights of injured persons? In other words, does a cost shifting from the medical professional who caused the injuries to the person who was injured or to a governmental agency achieve anything more than an illusory savings?

WHAT IS THE COST OF THE MEDICAL-LEGAL SYSTEM?

The American Bar Association does not purport to possess the expertise to analyze all of the reasons for escalating medical costs. We do, however, have the ability to analyze the interrelationship of the legal system and those costs. Moreover, we are able to determine the consequences of proposed legislation upon the American legal system and those seeking compensation for injuries.

The major components that have been cited as contributing to the rising cost of health care are:

- Reliance on modern, sophisticated and expensive treatments;
- Innovative treatment of illnesses, such as heart disease, AIDS and cancer;
- An aging population, which adds to Medicare and Medicaid expenditures;
- High administrative costs of the health care system; and
- The medical-legal system.

Studies concerning the medical-legal system show that its impact on the national expenditures is not only questionable but also insignificant.[1] The Congressional Budget Office states that medical-legal costs, as measured by medical malpractice insurance premiums, account for 0.74 percent of the national health expenditures.[2] The other component of cost attributed to the legal system is that of so-called "defensive medicine." Varying figures for the cost of "defensive medicine" have been estimated, ranging upwards to two percent of the total cost of our national health care.

To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. There is no agreement upon the definition.[3] That uncertainty has resulted in the inability to statistically measure the cost.[4] In published studies, "defensive medicine" has included erroneously the cost of the consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest.[5] Some have considered the cost of new technology and advancements in medical knowledge, care, and treatment. In that regard, patients expect the use of very modern, sophisticated and expensive technology to refine diagnosis and eliminate uncertainties.

Therefore, to examine the impact of the medical-legal system, the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There appears to be no study to measure that cost, and there appears to be no basis for assuming that competent and reputable physicians impose

such expenses upon their patients without a justifiable medical reason. The Congressional Budget Office concluded that "defensive medicine is probably not a major factor in the costs of medical care."[6]

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable.[7] When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.[8] Thus, if liability concerns are a deterrent, provisions that relieve physicians of concern regarding negligent practices can actually result in an increase of health care cost.

Because no reliable studies have been done to estimate the cost of so-called defensive medicine, the Office of Technology Assessment has been asked to study the issue and is expected to complete its study within the next twelve months.

MEDICAL MALPRACTICE LITIGATION

The cost of medical malpractice insurance, in part, reflects the cost of the medical-legal system. In contrast to the increase in health care costs, medical malpractice costs have decreased slightly. The number of medical malpractice claims peaked in 1985, and has continued to decline.

In 1989, malpractice insurance premiums were less than one percent of the total health care costs in the United States, and premium cost decreased by about four percent for 1990. The Physician Payment Review Commission agrees that the cost of malpractice insurance is "probably not excessive." In comparison to other components of health care costs, administrative costs, for example, are 10 to 24 times the cost of all medical malpractice claims.

WHAT ARE THE CONSEQUENCES TO THE PUBLIC OF PROPOSALS TO CAP NONECONOMIC DAMAGES OR ELIMINATE THE COLLATERAL SOURCE RULE IN MEDICAL MALPRACTICE CASES?

These type of proposals are ill-advised. Elimination of the collateral source rule solely favors physicians by passing on the cost of the medical injury to another health care provider. Often, an injured person has the benefit of health or disability insurance which pays for a portion of the additional medical costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a lien against its insured's recovery or pursue a subrogation claim. Under such proposals, the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health or disability insurer will be an increase in those premiums. The net result is no reduction in health care costs but a windfall benefit to the defendant physician and his or her insurer at the expense of the injured person.

Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. In fact, noneconomic injuries may far exceed the economic damages. These proposals, if enacted, would make seriously injured persons who are the least able to afford it receive less than full compensation while less seriously-injured persons would be fully compensated. This would be grossly unjust.

A bottom line is whether the economic benefits to the public in reducing health care cost is significant enough to warrant depriving other members of the public—injured persons—of full and adequate compensation from those responsible for their injuries. With the cost of the entire medical-legal system constituting less than one percent of health care costs, a pertinent inquiry is whether such proposals would have any noticeable impact except upon injured persons.

Such proposals would not eliminate the less than one percent of health care costs attributable to medical professional liability since no one seriously urges that physicians should be immune from liability. Rather, such proposals are directed at those injured persons who are ultimately compensated. One study indicates that only 25 percent of the persons who present malpractice claims are compensated. These victims of medical negligence are the subject of such proposals. Any savings in the cost of health care would be a small fraction of a percent. Thus, even on an economic analysis, such proposals, if implemented, will not have a measurable impact upon the cost of health care. Such proposals, however, would impact severely and dramatically upon the persons who are victims of medical malpractice.

Thank you for giving us this opportunity to present our views to you.

ENDNOTES

1. According to the *1992 U.S. Industrial Outlook* prepared by the U.S. Department of Commerce, national health care outlays accounted for approximately 13%

of the GNP, totaling $738 billion up about 11% from $666 billion in 1990. The medical-legal component in the same period, however, appears to have decreased.

2. Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.

3. The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. The AMA, moreover, recognized other reasons contributed to a affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care." Statement on behalf of the American Medical Association to the Senate Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 16, 1991, page 4.

4. The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates." *Physician Payment Review Commission 1991 Annual Report to Congress,* page 374. *See also* Patricia M. Danzon, *"Liability for Medical Malpractice."* Journal of Economic Perspectives, vol. 5, no. 3, Summer 1991, pages 51–69.

5. Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities. It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

6. Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 30.

7. Patricia M. Danzon, *"Liability for Medical Malpractice."* Journal of Economic Perspectives, vol. 5, no. 3, Summer 1991, pages 51–69. Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice.

The *Physician Payment Review Commission's Annual Report* also discusses other possible causes of inefficient and inappropriate defensive medicine.

- Physicians and hospitals benefit financially by delivering more care.
- Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford.
- So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care.

8. Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

9. *U.S. Industrial Outlook 1992,* Department of Commerce, page 43–2.

10. *1989 Profitability Study* (By Line By State) and *1990 Profitability Study* (By Line By State), National Association of Insurance Commissioners, 1990 and 1991. *Physician Payment Review Commission 1991 Annual Report to Congress,* page 372.

11. See Woolhandler S., Himmelstein D.U., *The Deteriorating Administrative Efficiency of the U.S. Health Care System.* New England Journal of Medicine, 1991; 324; 1253–1258. Administrative costs are estimated to range between 10% and 24% of health care costs.

12. The Department of Commerce, State of Minnesota, conducted a study of all claims filed with insurers in that state, North Dakota and South Dakota against physicians from January 1, 1982, through December 31, 1987. The study found that claims frequency did not materially change over the time period nor did the cost of defending such claims. The study also found no situation where punitive damages were awarded.

APPENDIX A

RESOLUTION APPROVED BY THE AMERICAN BAR ASSOCIATION HOUSE OF DELEGATES

FEBRUARY 11, 1986

BE IT RESOLVED,

1. The American Bar Association urges appropriate ABA entities, such as the Action Commission to Improve the Tort Liability System and the Commission on Professionalism, to continue to consult, where appropriate, with representatives of the American Medical Association and others in the health care industry, the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The Legal and Medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

2. Consistent with these goals, the American Bar Association adopts the following principles:

A. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

B. There should be rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

C. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

D. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

E. No disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

F. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

G. No justification exists for a special rule governing malicious prosecution actions brought by health care providers against persons who sued them for malpractice.

H. Trial courts should scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

I. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

J. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

K. The use of structured settlements should be encouraged.

L. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

APPENDIX B

RESOLUTION APPROVED BY THE AMERICAN BAR ASSOCIATION HOUSE OF DELEGATES

February 16-17, 1987
(Report No. 123)

Be It Resolved, That the American Bar Association adopts the following recommendations:

A. Insurance

1. The American Bar Association should establish a commission to study and recommend ways to improve the liability insurance system as it affects the tort system.

B. Pain and Suffering Damages

2. There should be no ceilings on pain and suffering damages, but instead trial and appellate courts should make greater use of the power of remittitur or additur with reference to verdicts which are either so excessive or inadequate as to be clearly disproportionate to community expectations by setting aside such verdicts unless the affected parties agree to the modification.

3. One or more tort award commissions should be established, which would be empowered to review tort awards during the preceding year, publish information on trends, and suggest guidelines for future trial court reference.

4. Options should be explored by appropriate ABA entities whether additional guidance can and should be given to the jury on the range of damages to be awarded for pain and suffering in a particular case.

C. Punitive Damages

5. Punitive damages have a place in appropriate cases and therefore should not be abolished. However, the scope of punitive damages should be narrowed through the following measures:

a. Standards of Conduct and Proof

Punitive damages should be limited to cases warranting special sanctions and should not be commonplace. A threshold requirement for the submission of a punitive damages case to the finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. As a further safeguard, the standard of proof to be applied should be "clear and convincing" evidence as opposed to any lesser standard such as "by a preponderance of the evidence."

b. The Process of Decision

(1) Pre-Trial - Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial - Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial - As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur wherever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical ratios (as reflected in the best available empirical data) between compensatory and punitive damages. If necessary to assure such judicial review, appropriate legislation should be enacted. Opinions issued by trial or appellate courts either upholding or modifying an award should specify the factors which were considered and relied upon.

c. Multiple Judgment Torts

While the total amount of any punitive damages awarded should be adequate to accomplish the purposes of punitive damages, appropriate safeguards should be put in force to prevent any defendant from being subjected to punitive damages that are excessive in the aggregate for the same wrongful act.

d. Vicarious Liability

With respect to vicarious liability for punitive damages, the provisions of Section 909 of the Restatement (Second) of Torts (1979) should apply. Legislatures and courts should be sensitive to adopting appropriate safeguards to protect the master or principal from vicarious liability for the unauthorized acts of nonmanagerial servants or agents.

e. To Whom Awards Should Be Paid

In certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the

award to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions. The novelty of such proposals and the absence of any adequately tested programs for implementing require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies. The concept of public allocation of portions of punitive damage awards in single judgment actions is also worthy of consideration to the extent workable methods of implementation may hereafter be developed.

D. Joint-and-Several Liability

6. The doctrine of joint-and-several liability should be modified to recognize that defendants whose responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff are to be held liable for only their equitable share of the plaintiff's noneconomic loss, while remaining liable for the plaintiff's full economic loss. A defendant's responsibility should be regarded as "substantially disproportionate" when it is significantly less than any of the other defendants; for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury.

E. Attorneys' Fees

7. Fee arrangements with each party in tort cases should be set forth in a written agreement that clearly identifies the basis on which the fee is to be calculated. In addition, because many plaintiffs may not be familiar with the various ways that contingency fees may be calculated, there should be a requirement that the contingency fee information form be given to each plaintiff before a contingency fee agreement is signed. The content of the information form should be specified in each jurisdiction and should include at least the maximum fee percentage, if any, in the jurisdiction, the option of using different fee percentages depending on the amount of work the attorney has done in obtaining a recovery, and the option of using fee percentages that decrease as the size of a recovery increases. The form should be written in plain English, and, where appropriate, other languages.

8. Courts should discourage the practice of taking a percentage fee out of the gross amount of any judgment or settlement. Contingent fees should normally be based only on the net amount recovered after litigation disbursements such as filing fees, deposition costs, trial transcripts, travel, expert witness fees, and other expenses necessary to conduct the litigation.

9. Upon complaint of a person who has retained counsel, or who is required to pay counsel fees, the fee arrangement and the fee amount billed may be submitted to the court or other appropriate public body, which should have the authority to disallow, after a hearing, any portion of a fee found to be "plainly excessive" in light of prevailing rates and practices.

F. Secrecy and Coercive Agreements

10. Where information obtained under secrecy agreements (a) indicates risk of hazards to other persons, or (b) reveals evidence relevant to claims based on such hazards, courts should ordinarily permit disclosure of such information, after hearing, to other plaintiffs or to government agencies who agree to be bound by appropriate agreements or court orders to protect the confidentiality of trade secrets and sensitive proprietary information.

11. No protective order should contain any provision that requires an attorney for a plaintiff in a tort action to destroy information or records furnished pursuant to such order, including the attorney's notes and other work product, unless the attorney for a plaintiff refuses to agree to be bound by the order after the case has been concluded. An attorney for plaintiff should only be required to return copies of documents obtained from the defendant on condition that defendant agrees not to destroy any such documents so that they will be available, under appropriate circumstances, to government agencies or to other litigants in future cases.

12. Any provision in a settlement or other agreement that prohibits an attorney from representing any other claimant in a similar action against the defendant should be void and of no effect. An attorney should not be permitted to sign such an agreement or request another attorney to do so.

G. Streamlining the Litigation Process: Frivolous Claims and Unnecessary Delay

13. A "fast track" system should be adopted for the trial of tort cases. In recommending such a system, we endorse a policy of active judicial management of the pre-trial phases of tort litigation. We anticipate a system that sets up a rigorous pre-trial schedule with a series of deadlines intended to ensure that tort cases are ready to be placed on the trial calendar within a specified time after filing and tried promptly thereafter. The courts should enforce a firm policy against continuances.

14. Steps should be taken by the courts of the various states to adopt procedures for the control and limitation of the scope and duration of discovery in tort cases. The courts should consider, among other initiatives:

(a) At an early scheduling conference, limiting the number of interrogatories any party may serve, and establishing the number and time of depositions according to a firm schedule. Additional discovery could be allowed upon a showing of good cause.

(b) When appropriate, sanctioning attorneys and other persons for abuse of discovery procedures.

15. Standards should be adopted substantially similar to those set forth in Rule 11 of the Federal Rules of Civil Procedure as a means of discouraging dilatory motions practice and frivolous claims and defenses.

16. Trial judges should carefully examine, on a case-by-case basis, whether liability and damage issues can or should be tried separately.

17. Nonunanimous jury verdicts should be permitted in tort cases, such as verdicts by five of six or ten of twelve jurors.

18. Use of the various alternative dispute resolution mechanisms should be encouraged by federal and state legislatures, by federal and state courts, and by all parties who are likely to, or do become involved in tort disputes with others.

H. Injury Prevention/Reduction

19. Attention should be paid to the disciplining of all licensed professionals through the following measures:

(a) A commitment to impose discipline, where warranted, and funding of full-time staff for disciplinary authorities. Discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state in order to safeguard the rights of all citizens.

(b) In every case in which a claim of negligence or other wrongful conduct is made against a licensed professional, relating to his or her profession, and a judgment for the plaintiff is entered or a settlement paid to an injured person, the insurance carrier, or in the absence of a carrier, the plaintiff's attorney, should report the fact and the amount of payment to the licensing authority. Any agreement to withhold such information and/or to close the files from the disciplinary authorities should be unenforceable as contrary to public policy.

I. Mass Tort

20. The American Bar Association should establish a commission as soon as feasible, including members with expertise in tort law, insurance, environmental policy, civil procedure, and regulatory design, to undertake a comprehensive study of the mass tort problem with the goal of offering a set of concrete proposals for dealing in a fair and efficient manner with these cases.

J. Concluding Recommendation

21. After publication of the report, the ABA Action Commission to Improve the Tort Liability System should be discharged of its assignment.

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Mr. Chairman, the American Physical Therapy Association (APTA) commends you for holding this series of hearings on comprehensive health care reform and appreciates the opportunity to provide this testimony.

The American Physical Therapy Association (APTA) is a professional membership organization representing over 52,000 physical therapists, physical therapist assistants and students of physical therapy across the United States. APTA has long been committed to improving and ensuring access to appropriate and necessary health care.

It is APTA's firm belief that every American should have equal access and equal availability to comprehensive, high quality health care services, including physical therapy. Practicing in one of the fastest growing professions, physical therapists have sought to improve the health and quality of life of people of all ages for over 70 years.

APTA believes that any comprehensive health care reform should provide coverage beyond the services provided for under the current Medicare system, particularly in the areas of rehabilitation services, long term care, catastrophic and chronic care. Specifically, APTA believes the following components should be included in any health care reform package:

- a nationwide and uniform program for *long-term care* and *catastrophic health insurance* for all those currently eligible under the Medicare program;
- coverage for self-help and adaptive devices and all durable medical equipment not currently reimbursed;
- a nationwide and uniform system of benefits for those who cannot provide for their own health insurance with particular emphasis on the needs of the children of the uninsured;
- extension of rehabilitation benefits on a periodic basis, to cover those individuals who have had previous restorative care but are now at a maintenance level in order to assure that they do not lose the capability that they have developed;
- expansion of the availability and accessibility of *health screening, preventive* and *early care services* by providing recognition and reimbursement to a variety of health care personnel; and
- increased educational funding to ensure a sufficient number and variety of health care personnel in order to meet continuing health care needs.

While APTA has not endorsed any one proposal, we do appreciate this opportunity to put forth recommendations which we believe are necessary for a truly effective comprehensive health plan.

Many of the comprehensive health care proposals before Congress call for a federal commission or commissions to oversee health care as an essential component of rebuilding the system. We urge, however, that recognition also be given to the need for such *health care review boards to truly and broadly represent all health professions* who are providers within the system. The Federal government must begin to recognize the fact that Medicine does not equal health care, that *health care,* when it must be rendered, is competently rendered by many whose training is different than a physician's but certainly whose training provides them with the competence to provide skillful care within the scope of that training.

In this same vein, *administrative simplicity* is not just desirable—it is imperative. Bureaucratic hierarchies must be streamlined and paper work at all levels—from payor to provider—must be decreased. A single form for reimbursement must be instituted, and it should be standardized throughout the country with all carriers using exactly the same format with no additional requirements tacked on (e.g. requiring photocopies of progress notes, etc.)

Truly effective health care reform must address the following:

PHYSICIAN SELF REFERRAL

The APTA has long opposed physician referral for health care services to a facility where the referring physician has a financial interest, a situation we characterize as referral for profit. Evidence gathered in 1991 by the Florida Cost Containment Board concluded that physicians utilize services at a far higher rate when they have an investment or financial interest in a health care facility. The Florida study found that physician self-referrals result in a significant increase in public and private sector health care costs.

This adverse impact and unethical conflict of interest has been shown to affect physical therapy services. The Florida study specifically reported that physician-owned physical therapy centers provided 43% more visits per patient than other physical therapy centers, generating approximately 31% more revenue per patient.

The Florida study also examined physical therapy services which are delivered in comprehensive rehabilitation facilities and found that, in this setting, 35% more physical therapy visits were provided per patient when the facility was physician owned. These 35% more visits generated approximately 10% more revenue per patient.

The pattern which emerges when the number of visits are expressed relative to the sum of full time equivalent licensed physical therapists and physical therapist assistants is that facilities with physician ownership rendered about 40% more visits per full time equivalent licensed physical therapy practitioner than did other facilities. In addition, the study found a tendency in the physician-owned physical therapy centers to provide care by substituting nonlicensed medical workers for licensed practitioners. According to the study, "These findings indicate that joint venture (i.e., ventures with physician ownership) physical therapy centers provide a lower quality of care because both licensed therapy workers and nonlicensed workers spend less time with each patient."

As long as physician referral is required and as long as physicians are permitted to invest in services to which they refer, there can be no semblance of competition. Those physical therapists who choose not to have some financial arrangement with a referring physician will experience steadily diminishing referrals as more and more physicians decide to grab a piece of the pie and monopolize the supply for which they are certifying the demand.

We are especially encouraged by the fact that this issue is being addressed in the House of Representatives. Not only does H.R. 5502, which is currently pending in the Ways and Means Committee address this issue, but remedies are also a part of H.R. 5325 which has been proposed by the Republican leadership in the House.

Despite the often striking differences between these two approaches to health care reform, it is both instructive and encouraging that similar approaches are embraced by both parties in the House in an effort to eliminate this pernicious practice. We urge the Senate to take similar action to eliminate this abuse from the delivery of health care services in all payor settings.

IMPROVE ACCESS TO PHYSICAL THERAPY SERVICES/FREEDOM OF CHOICE

A comprehensive health care proposal should emphasize the many strengths of our current system and seek ways to expand this system. The current system features the potential for freedom of choice. Specifically, under our current system, individuals have the freedom to choose their own physician and hospital. Yet this freedom of choice is withheld in many other contexts. For example, although physical therapists are licensed in every State and are required to complete formal education and clinical training, 23 States, the District of Columbia, and Puerto Rico, require a physician referral as a prerequisite to the delivery of physical therapy services, despite the fact that the legislatures of these States have determined physician referral to be superfluous and unwarranted as a absolute matter of course.

Freedom of choice is further restricted by Medicare laws which mandate physician referral across the board, even in those 27 States where the legislatures have enacted laws to allow patients to be treated directly by a physical therapist. In addition to referral, Medicare further requires thirty day physician recertification of the Medicare beneficiary's continuing need for physical therapy and thirty day physician visits to demonstrate that the beneficiary is under the care of a physician.

In many cases, there is no clinical reason for the patient to be under the care of a physician. In these cases it is the care of a physical therapist that is needed, not the services of a physician. Yet Medicare will not cover the services of a physical therapist unless the patient is under the care of a physician.

Elimination of policies such as these would greatly improve access to needed health care services. In fact the only beneficiaries of these roadblocks are those physicians who are paid to recertify the continuing need for services and who are also paid to keep Medicare beneficiaries under their care when it is not even their care that is required.

Mandatory referral limits the right of the public to make their own health decisions and to receive care from the practitioners of their choice. Greater access within the current system will promote earlier, more effective and less costly medical care.

Faced with severe shortages of rehabilitation professionals, including physical therapists, the 27 States referenced above have responded by removing these archaic and counterproductive barriers to access. We encourage Congress to do so also with respect to federal health care programs. Until this step is taken, however, we urge that Congress at least defer to the considered judgment of the State legislatures in this area of regulating professional practice. Innovative approaches to improving access to health care services should be encouraged rather than stymied.

PREVENTION

Physical therapists also play an important role in prevention, a key component in any health care reform proposal. Specifically, prevention should include expanding access to primary health care in order to provide comprehensive health education, health promotion, and disease prevention activities. For these measures to play the important role that they must in the future health of all Americans, physical therapists must be included in any health prevention plan.

Physical therapists are uniquely qualified to develop personalized conditioning programs that help prevent injury and promote fitness. In determining an individual's functional and fitness level, therapists evaluate aerobic capacity, body structure, body composition, body balance, muscular flexibility and muscular strength. Physical therapists are qualified to teach prenatal and post natal exercise classes, perform posture screenings in local schools, teach back-care classes to prevent back pain and injury, and identify potentially dangerous work sites.

Individually and collectively all of us have an obligation to preserve our own health, however an investment in physical therapy services in any health care reform package will result in healthier behaviors and individuals, a critical component to economic cost savings.

CONCLUSION

Mr. Chairman, the APTA recognizes that a variety of health care reform proposals have been put forward by members of this Committee, others, and the President. Clearly, the statistics on the number of uninsured and underinsured demand attention. Although the current American system may deliver the world's best quality care and the world's most sophisticated health technology it is, inaccessible and unaffordable to millions. The United States needs comprehensive reform. A truly comprehensive approach should offer a wide range of services, in a variety of settings.

We must begin to reform with a revamping of the public's entire perception and outlook towards health—and that should not be one of care, but one of health promotion and maintenance of health. The undeniable statistics of the rapidly approaching 21st century indicate that the numbers of individuals between the ages of 65 and 75 and between 75 and 85 which have consistently risen within the 1980s and early 1990s will continue to increase. The impact of these persons over 65 years of age who are prone to debilitating, disabling disorders is awesome to all of us involved in physical therapy and certainly to every other member of the health community. It is estimated that 4 out of every 10 Americans will have two or more chronic conditions by the year 2000.

To meet the challenges for major reform of the health care system, the APTA offers several observations. First and foremost, physical therapy and other health professional practitioners must always be guided by the dual philosophies of primary prevention of long term health problems and, when that is not possible, then secondary prevention whenever possible to preclude the problem from becoming more severe or to preclude its recurrence entirely. Thus, prevention programs in health reform must go well beyond well-baby programs and routine physical check-ups. *Adult and senior citizen health promotion programs must be inextricably woven into the fabric of the health system's design.*

True health care reform requires fundamental revisions. Abuse within our system benefits no one and places unnecessary stress on our economy. Physicians and other primary care providers are increasingly playing a self-serving role where financial interest or investment in health care is the bottom line. Such situations lead to misutilization, reduced quality and increased, unnecessary costs.

The APTA believes that a truly comprehensive approach to reform will provide a continuum of health care and support services throughout an individual's life. Long-term care, chronic and acute care, preventive care and freedom to choose a health care provider must be an integral part of health care reform.

While Congress and the Administration seek a legislative solution, the APTA will be happy to work with the Committee to enact necessary reforms in the health care system that will allow Americans access to quality, cost-effective health care, including rehabilitation services.

AMERICAN SUBCONTRACTORS ASSOCIATION, INC.,
Alexandria, VA, May 29, 1992.

Hon. LLOYD BENTSEN, *Chairman,*
Committee on Finance,
U.S. Senate,
Washington, DC.

Dear Chairman Bentsen: The American Subcontractors Association (ASA) would like to express its strong commitment to reform of our current health care system. Although many proposals have been introduced in Congress, little action has been taken thus far to seriously address the issue of reform.

The American Subcontractors Association is a national trade association with more than 7,000 member firms representing all major construction trades in 72 chapters nationwide. ASA is the only national organization that speaks exclusively for the interests of union and non-union construction subcontractors, regardless of trade specialty.

Earlier this year, the ASA Board of Directors met to discuss possible health care reform options. ASA would like to inform you about the health care initiatives that were approved by our members.

ASA members feel that it is imperative that our first goal must be to reduce the current cost of health care. ASA suggests that the first step toward cost reduction be legislative reform of the civil. justice system with respect to medical malpractice. Escalating costs of malpractice settlements are being directly shifted to the consumer, thus making medical care unaffordable for the majority of Americans.

Secondly, ASA strongly advocates the development and implementation of standardized claims and data forms. Administrative costs would be substantially reduced and the savings could be passed along to the consumer.

In addition to cost reduction, ASA recommends several initiatives to better enable the consumer to retain health insurance. An increase in the tax deduction for the cost of providing health insurance for the self-employed would make health insurance more affordable. This savings would give the self-employed an incentive to provide health insurance, while also easing the financial burden associated with maintaining a health insurance program.

ASA supports legislation to establish a program of voluntary federal certification of managed-care programs and of utilization review programs. These programs would place a more effective system of checks and balances on the propriety of medical services provided to a patient.

Finally, ASA recommends that legislation be enacted to prohibit insurers from denying coverage on the basis of pre-existing conditions. Further, ASA believes legislation should be enacted to restrict variations in premiums for small employers to factors such as health status, claims experience, length of time since the policy was first issued, industry, or occupation. Small employers are finding it increasingly difficult to absorb the increased costs of health insurance for employees and these initiatives would be a step in the right direction.

The American Subcontractors Association urges the Committee (Subcommittee) to seriously address the issue of health care reform during this session of Congress. In so doing, it is ASA's hope that you will keep in mind the options I have outlined in this letter. Instead of increasing the burdens on businesses and other consumers, cost reduction is the most critical element to making health care more affordable for everyone.

ASA thanks you in advance for your efforts and sincerely appreciates any positive action you may take in this regard.

Sincerely,

WAYNE T. RUTH, *Chairman, Government Relations Committee, American Subcontractors Association.*

STATEMENT OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

I. INTRODUCTION

The Association of Private Pension and Welfare Plans (APPWP) is pleased to submit these comments to the Senate Committee on Finance on concerns we have on health care reform. The APPWP is a nonprofit organization founded in 1967 to protect and foster the growth of America's private employer-sponsored employee benefit system. Its more than 400 members include both large and small plan sponsors as well as plan support organizations such as investment, and actuarial firms, and

other professional benefit organizations. APPWP members directly sponsor or administer pension and health benefit plans covering more than 100 million Americans. All APPWP members provide health insurance for their employees, and most, but not all, members are self-insured. Our members represent the views of a very broad range of employee benefits specialists who plan, design, provide and pay for health care benefits.

The APPWP fully supports universal, equitable access to quality health care. As a national policy, this makes sense because as President Bush has stated, health care is a right. It also makes sense because universal access would reduce certain practical and economic inefficiencies in our system that result in costly use of emergency facilities, poor health and loss of productivity due to lack of preventive or primary care, and extensive cost shifting among payers. Also, from a purely parochial view, American business needs a current and future workforce that is healthy.

The business community will support reform that incorporates these principles: that our system remain a voluntary private sector, employer-based system, that the costs of our system be fairly shared among all payers, that the costs and means of paying for reform be stated realistically and rationally up front, and that sustained and system-wide cost containment be its hallmark.

II. AN EMPLOYER-BASED SYSTEM IS THE MOST APPROPRIATE SYSTEM FOR THE UNITED STATES

The APPWP strongly believes that any reform of America's health care system be employer-based. A health care system that is basically a private system is more likely to sustain a high quality and cost-effective delivery system. America's employers are doing a most commendable job of providing health care for their employees and dependents. Currently, America's employers provide health care coverage to over 188 million American workers and their dependents; over eighty percent of the civilian, full-time workforce is covered through employer-sponsored plans. Even among smaller employers, where coverage is the weakest, and where much attention has been focused in terms of reform, coverage is still significant: nearly two-thirds of companies with fewer than 100 employees provide health insurance to at least some of their employees; 60 percent sponsor a plan for all their employees.

Furthermore, employer health care benefits are a real bargain for the U.S. Treasury. Tax incentives for health care encourage employers to provide these benefits to almost all of their regular workers in the low- to middle-income ranges. We've heard much lately about altering the tax status of these benefits and capping either or both the employer's deduction, or the employee's exclusion, of the health care benefit. We wish to emphasize, however, that, according to "Benefits Bargain," a recent APPWP study of the tax subsidy for private sector benefits, that workers with family incomes below $20,000 get a relatively larger share of the actual benefits and a larger share of the related tax expenditures than their share of federal income taxes. Our study showed that private health benefits paid are 5.3 times foregone federal revenues.

This employer-based system is neither static nor cheap. But the APPWP believes that sustaining and building upon the private sector, employer-based health care system is the safest, wisest course for expanding and improving America's health care system. The plurality and flexibility of such a system are highly valued by the American people. As the needs of our employees and their families change, and the character and expectations of our workforces change, so too do the programs we design and offer our employees change to fit the times. The flexibility of a private system permits technological and service-oriented developments that provide the best medical care in the world.

The substantial role of employer plans in our system is by itself a good argument for continuing to organize health care financing through employers. The costs, dislocations, and redistribution of risk that would result from changing this role are so substantial that it seems hardly practical to consider a complete restructuring of this role.

Employers are more able than governments to tailor health plans to the needs of their particular workforces. This capacity to quickly design or modify health benefits also contributes to the employers' unique ability to experiment with new ideas in providing benefits, to modify benefits to meet changing health care delivery patterns, and to discover new ways to manage the cost of health benefits. There has been considerable testimony from employers reflecting the innovation and energy that is being channeled today into improving the management of health benefits.

Employer provision of health benefits is also an effective way to organize large groups that efficiently distribute risk. Having individuals acquire health insurance through employment ensures that their participation in health insurance groups is

motivated by factors other than the cost of health insurance and thus not an interference with the random assignment of health risk.

Employers also bring a business perspective and a concern about cost-effectiveness to the health care system. Employers can operate as knowledgeable purchasers to gain the greatest value for patients from health services they purchase. While it is also possible for government to act as a knowledgeable purchaser on behalf of patients, it is a more difficult role for a political entity that must be responsive to a variety of constituencies in addition to the patients themselves. Government's concerns about health care resource limitations may be diluted by conflicting concerns about provider opportunities.

III. ERISA'S FRAMEWORK FOR EMPLOYEE BENEFITS AND THE NEED FOR PREEMPTION

Employer responsibilities and employee rights in the provision of employee benefits are governed by the Employee Retirement Income Security Act of 1974 (ERISA). The relationship of ERISA to health benefits is not always well understood, and ERISA has often been credited or blamed for a variety of health care consequences not directly related to this Act.

ERISA is in its essence a broad umbrella of protection for participants in employee benefit plans, including health plans. For health benefits, ERISA requires plans to report and disclose plan provisions to the federal government and to plan participants, sets standards of fiduciary responsibility, provides participants with private rights of action to enforce their claims to benefits, and requires the opportunity for continuation of coverage under group health plans after termination of employment. For-pension benefits, ERISA provides additional standards for participation and vesting of benefits and funding of pension plans, as well as a system of pension plan termination insurance.

In order to maintain consistent treatment of participants of plan sponsors operating in a number of states, ERISA (under section 514) broadly preempts "any and all" state laws related to employee benefit plans. While this section went on to exclude state laws regulating insurance, banking or securities from ERISA preemption, it further specified that employee benefit plans are not to be deemed to be insurance, banking or investment companies for the purpose of state regulation.

The Supreme Court, in *Metropolitan Life Insurance Co.* v. *Massachusetts,* interpreted section 514 of ERISA to create two separate classes of employee benefit plan: "self-insured" and "insured." Under the court's distinction, ERISA governs self-insured health plans—plans in which a plan sponsor bears the risk for employees' health costs, though they may purchase administrative services only (ASO), stop-loss protection, or minimum premium plans (MPP) from an insurance company. State insurance flaws apply to plans that are entirely purchased from insurance companies.

The single nationwide regulatory framework that is provided through ERISA preemption is a necessity for companies, such as many APPWP members, that operate employee benefit plans in more than one state. ERISA has enabled these multi-state employers to avoid having to separately qualify or meet divergent state requirements with a single plan in a multiplicity of jurisdictions. It has also protected participants by setting uniform standards for the financial operations of employee benefits plans and providing participants with uniform private rights of action to ensure that benefits are paid.

The limitation of ERISA's nationwide regulatory structure to self-insured health plans has left insured plans subject to added costs imposed by state premium taxes and state-mandated health benefits. The advantage of experience rating a large group and managing its health care costs, added to the protection from state taxes and mandated benefits afforded by ERISA preemption has encouraged large numbers of plan sponsors to drop their insured plans and seek ERISA's protection through self-insurance over the last decade. Today, health plans in which an employer has assumed all or part of the risk (e.g. ASO, MPP or stop loss plans) account for 55 percent of total commercial insurance business. While self-insurance is most typical among the largest employers, a recent survey by benefits consultants and APPWP member, A. Foster Higgins & Co., Inc. indicates that small employers (those with fewer than 500 workers) are converting to self-insurance at a most rapid rate.

Those plan sponsors that cannot self-insure, for one reason or another, particularly the smallest businesses, are left behind to cope with state regulation, including the increasing burden of state-mandated health benefits. State mandates reduce the flexibility that plan sponsors have to meet employee needs and control costs. They impose additional costs by requiring that plans cover specific benefits (such as *in vitro* fertilization, or long term care); pay groups of non-physician providers (such

as chiropractors, podiatrists, naturopaths or acupuncturists); or insure specific participants, (such as non-custodial children or dependent students).

Although proponents have argued that mandating benefits can reduce costs—for example by substituting lower-paid health professionals for physicians—the experience with most mandated benefits has been that they *increase* costs by requiring payment to new practitioners for categories of services not previously covered. A study by the Health Insurance Association of America, (HIAA), of health insurance costs in Maryland in 1986 concluded that, overall, state mandated benefits raised the cost of family coverage there by 17 percent.

Despite a growing concern about state benefit mandates, the total number of mandates in force in the fifty states continues to grow rapidly. The number of benefit mandates in effect has risen from fewer than 200 in the mid-1970s, to 816 as of 1990, according to the Blue Cross and Blue Shield Association. In fact, the most recent two-year period, 1989–90, has seen the largest single enactment of new benefit mandates yet—116 new laws! In all, there now are more than 50 different types of mandates benefits in force, with as many as 35 mandates in effect in the most mandate-prone states. The variability in benefit mandates from State to State also adds costs. Insurers who market plans in more than one State tend to incorporate the sum of all mandated benefits in the States in which they operate in order to provide uniform plans for their customers.

While the overall trend is still toward more mandates, a few States have begun to respond to concerns about state benefit mandates by enacting a series of "anti-mandate" laws. In the last few years, sixteen states have enacted laws requiring an evaluation of the financial and social impact of additional mandates as a condition for enactment. Three states prevent mandates from applying to insured plans until they also apply to self-insured plans. Nine states have enacted mandated benefit waivers to enable insured plans for small groups (25 to 50 or fewer) to meet a lower minimum state standard and avoid mandated benefits.

We believe that it is an unfortunate result of the limitations placed on ERISA that plan sponsors' decisions to self-insure are motivated more by the need to escape burdensome state requirements than by a judgment that self-insurance is the most effective way to bear health risks and manage health insurance costs. Not all employers are large enough or have good enough risks to self-insure.

Small employers should have the same advantages that larger employers can derive from large pools and self-insurance—risk spreading, negotiating discounts with providers, and protection from state benefit mandates. While a variety of pooling arrangements have been tried for small employers, they have often been unable to overcome the adverse selection problems that arise from the voluntary association of separate risk groups.

Employers too small to self insure may have some of the advantages of pooled risk, preemption of State mandated benefits, and managed care by joining multiple employer welfare arrangements (MEWAs). However, an uncertain regulatory environment continues to restrain the use of MEWAs. Some uniform approach to defining and regulating these voluntary associations, and other small market reforms are necessary if small businesses are going to have an effective mechanism to benefit from the risk-pooling of large self-insured plans.

APPWP believes a better solution is to extend the protection afforded under ERISA to all employee benefit plans—whether insured or self-insured—and clearly limit the state regulatory involvement to insurance reserve requirements and consumer protection. Preemption of State benefit mandates should apply to the health benefit plans of all employers. If that is not possible, the Congress should at least give small businesses nationwide waivers from state benefit mandates similar to the state-based waivers already in effect in nine states.

Laws to Restrict ERISA Preemption are Misdirected

APPWP is particularly concerned about bills introduced in the House and Senate this year aimed at sheltering a class of State law from ERISA preemption. The proposed legislation is a response to the U.S. Supreme Court's decision in *Pilot Life Insurance Company* v. *Dedeaux* (481 U.S. 41(1987)) in which the court ruled that ERISA preempted state common law causes of action.

H.R. 1602, introduced by Rep. Howard Berman (D–CA), would add a new clause to ERISA section 514(b)(2)(A) to "save" from preemption state statute or common law that provides a remedy for unfair insurance claims practices against insurance companies or other insurers.

APPWP is very concerned about these bills as they would specify additional statutory limits for the application of ERISA preemption. Restrictions in ERISA preemption that would expand State regulatory authority over employee benefit plans would impair the ability of employers to design uniform plans and manage them ef-

fectively to meet the needs of their workforces. It would also raise questions about the uniform application of private rights of action now wisely provided under ERISA. In particular, H.R. 1602 would expand the separate treatment now accorded insured and self-insured plans, and raise the costs of insured plans by exposing their managed care efforts to significantly greater liability under State common law, and take us in the opposite direction of cost containment and malpractice reform most all of us seek.

IV. COST CONTAINMENT OUR BIGGEST CHALLENGE; LIMITS TO COST SHIFTING OUR MAJOR OBJECTIVE

Just as we employers struggle with accommodating society's changing definition of family and family needs, so too are we faced with the bigger struggle of containing health care costs that already represent one-hundred percent of U.S. corporate after-tax profits. The 1 980s saw explosive health bare cost increases for American corporations, with double-digit increases occurring almost annually. Per capita costs in the U.S. increased 139 percent in the decade of the 1 980s, from $ 1026 in 1980 to $2425 in 1990; per employee costs grew to $3161 in 1990, from $2600 a year earlier. National health care expenditures have increased at twice the rate of general inflation for the last ten years. From 1988 to 1990, health care costs rose 46.3 percent, and have grown to represent 14 percent of payroll in 1990 from 5 percent in 1980. Corporate health care spending, which now represents 30 percent of total national health care spending, also represents 4.2 percent of private gross domestic product (GDP), from 1.3 percent at the beginning of the 1980s. Health care benefits have come to represent 46 percent of employee benefit costs, up from 24 percent in 1967. These cost increases parallel similar health care cost increases for society as a whole, and point to our biggest challenge in health care reform. There is a limit to what U.S. corporations can pay for health care, and a limit to what level of benefit support can go from pensions to health care.

Due to our unique multi-payer system, not all payers felt these cost increases equally. In the 1980s, more than ever before, American business drew the short straw on costs, and came to represent the ultimate cost "shiftee"—the payer to whom the bulk of uncompensated or under-compensated care was ultimately passed. Cost-shifting has been estimated to represent an 11 percent tax on corporate America's health care bill.

The apparent non-stop escalation in health care costs and Americans' apparent insatiable appetite for health care services is being challenged strongly by government and business, but it still appears that health care inflation is winning. Throughout the 1980s, as costs threatened corporate bottom lines, and our ability to compete with other industrial trading partners, new approaches to cost containment were born. For the government payer, diagnostic-related group (DRGs), reimbursements ushered in a new era for America's hospitals, just as the impending reform of physician reimbursement, the resource-based relative value scale or RBRVS, will do the same for America's physicians. However, corporate America is sadder but wiser since DRGs came into being. While we applauded the government's attempts to contain rising Medicare expenditures, we have come to realize, both through Medicare and Medicaid, that when providers believe they are being underpaid, charges to private payers rise. It is with some anticipation, and some trepidation, that we watch as RBRVS come into effect.

Corporate America has done much to contain its costs in the late 1980s through designing and implementing managed care programs. As all employers deploy some features of managed care, such as negotiated discounts with preferred providers, some of the impact of cost shifting can be lessened, but not all. We urge that any reform of our health care system be based on the principle that all payers must pay their fair share. Cost shifting may be impossible to eliminate entirely from a private-sector-based health care system with many payers, but much can be done to reduce significantly cost shifting from public to private sector. America's employers wish to work closely with policy makers to assure that cost shifting is reduced.

The APPWP is not prepared to endorse spending targets or caps or aggressive rate regulation by government bodies at the state or federal level. Rate regulation is not an attractive option for American business, no matter what sector of the economy is being discussed. As pension plan designers and providers as well as health care plan providers, our members can tell you, that our private sector pension system is so burdened with regulation it can barely breathe, let alone grow. Despite our great faith in managed care and its expected rapid evolution to new forms of financing and delivery of care, most of our members remain pessimistic about our long-term capability of not only reducing health care costs, but of at least keeping annual increases near even with the general rate of inflation.

As representatives of corporate payers and insurers, we can assure you that the APPWP's views on this matter will represent a sound consensus as to how far the private sector is willing to permit intervention in the health care market place.

The APPWP believes strongly that we must effectively control the growth in national health expenditures and that requires a national cost management policy. This policy should build upon the existing employer-based, multiple payer system and encourage a reliance on managed care techniques to eliminate unnecessary medical care and improve the quality of care for patients.

A national program to manage the cost of providing health care should include:

(1) An end to cost shifting from government to private payers and among private payers through an improvement in Medicaid payment rates and through opportunities for private payers to benefit from Medicare methods in the payment of providers;

(2) Efforts to expand the use of managed care techniques to all health plans—particularly to develop methods to extend managed care to small employers—including government plans, and Federal preemption of State anti-managed care laws;

(3) Broad ERISA preemption of State laws affecting benefits and coverage under employee benefit plans, including state benefit mandates;

(4) Efforts to increase the involvement of employees in selecting and paying for health care coverage through greater cost sharing and education;

(5) Additional Federal resources to improve the quality of health care through an expansion of research in medical outcomes, and an effort to improve the use of outcome information in treatment and coverage decision, including the development of physician protocols and national technology assessment;

(6) Medical malpractice reform, including the development of standards of negligence and treatment practice guidelines, the use of arbitration, limits on punitive damages.

(7) Expansion of health insurance coverage should build upon our employer-based system without resorting to the use of rigid employer mandates or the disincentives of taxes on health benefits.

V. MANAGED CARE CAN EFFECTIVELY CONTROL AN EMPLOYER'S COSTS

The experience of our member companies with managed care initiatives teaches us that managed care can help control a company's soaring costs while enhancing the quality of health care for employees. Employers and insurers are experimenting with alternative approaches to managing employee utilization of health care, selecting qualified providers, and reducing unnecessary medical care to control costs. APPWP supports efforts to encourage broader use by employers and the public sector of known successful managed care techniques.

State Anti-Managed Care Laws May Interfere

Unfortunately, employer and insurer innovations in managed care are increasingly encountering resistance from provider interest groups and growing efforts by State legislatures to limit managed care practices. Several States have passed or are considering laws that would limit utilization review, restrict the formation of provider networks, or require "freedom-of-choice" of pharmacies (preventing use of mail order or formularies) for prescription drug purchases.

Utilization review limitation includes efforts to restrict the use of non-local medical protocols, impose credentialing or residency restrictions on physicians performing utilization review, prohibit utilization review of psychiatric, chemical dependency or chiropractic treatment, or impose stringent appeal requirements. Network restriction and "freedom-of-choice" efforts would limit the use of selective contracting, the exclusion of non-network providers, and the negotiation of reimbursement discounts.

Laws that would prevent payers from holding providers to accepted standards of practice and restrict payer reviews of reimbursement claims interfere with efforts to reduce unnecessary and inappropriate medical care. APPWP believes the continuing enactment of State "anti-managed-care" laws will tie employers' hands in the effort to control their health care costs, and will contribute to an escalating level of health care expenditures in the system as a whole. The APPWP is concerned about anti-managed care efforts sweeping the country and supports federal legislative efforts to preempt State laws that would interfere with the operation of managed care activities.

VI. EXPANDING ACCESS THROUGH THE VOLUNTARY SYSTEM

There are several general public policy options under discussion that would significantly expand access for the uninsured. For those who think only the govern-

ment can adequately and fairly provide health care for the American people and contain costs, a one-payer government-sponsored social insurance program is espoused. For those who believe that the employer-based system implies a responsibility for all employers to provide all workers with health care benefits, mandates of some dimension are prescribed. For those who believe that there is already too much government involved, even with the private sector, elimination or limitation of federal tax subsidies for employer-based health care benefits is advocated, with some even suggesting that individuals be mandated to provide their own health benefits with the aid only of tax credits and not their employers.

As strong advocates of the private sector approach, the APPWP advocates these approaches to expanding access:

- a serious, long-term battle plan to contain health care costs across the board and improve the operation of the health care marketplace in the United States;
- increased incentives for employers to provide and maintain health benefit programs for their employees, including an end to cost shifting, retention of current tax subsidies for private health care benefits, small market insurance reforms, pre-emption of state benefit mandates, expansion of managed care, etc.;
- full deductibility of health insurance premiums for the self-employed; and
- a credible public program, such as a restructured or reformed Medicaid, that would not only cover all poor persons, but provide equitable and rational provider reimbursements. Expanding direct provision of services to targeted populations should also be included. Such a renewed public health care program would provide an attractive buy-in or buy-out option for the working uninsured as well. We recognize that a viable public program for the uninsured must include the nonpoor in order to be adequately funded by the government, and would require significant, additional revenues.

The APPWP categorically rejects a government sponsored one-payer, one-size-fits-all health care system as an answer to our Nation's health care dilemma. We can assure members of Congress that you do not want to be in the position of an employee benefits manager, having to decide what coverage you can afford for our plan's participants; which services, treatments and providers would be covered, and who would receive what kinds of treatments, surgery, or transplants. For that is what would happen under a one-payer system in our form of government: the Congress would have to decide ultimately many of these critical details. This is a job, in all due respect, that is not suitable for elected representatives.

Also, many who advocate a government system maintain that its enormous expense, which is usually woefully underestimated by its advocates, would be "covered" by the savings realized from reduced administrative costs. We do have high administrative costs in our system, and there are ways to reduce those costs, such as universal claims forms and electronic billing, and other such improvements the APPWP would support. However, we believe that if you want to know what's going on in your system, and better manage it, you have to spend some money. Duplication, unnecessary paperwork—which applies to both the private and public sectors—can and must be reduced. We're swimming in paperwork. But the suggestions that we should emulate the Canadian administrative procedures seem attractive at first glance, but on closer examination, its flaws become more apparent. Canada "manages" its system basically through the means of global budgets, and less with the sensitive hand guided by hard data and analysis. The additional administrative dollars being spent on managed care are paying back handsomely in savings and improved quality.

First, much of what has been said about administrative costs exaggerates that cost and its contribution to overall health care cost inflation. Second, much of our so-called administrative costs go toward finding out what goes on in our system. We collect extensive, critical data about our health care system and how it is operating in order to have a better idea about its failures, successes, and weaknesses. These data help us understand and manage our system better. Canada, and other nations with simple and low-cost administrative systems, now wish to emulate our information gathering capabilities in order to begin to better and more sensitively manage their systems. While there is much that we can do to simplify and lessen administrative costs, we must be careful not to overlook its positive aspects.

We believe that access can be enhanced through such incremental changes to the small health insurance market and by containing costs. The APPWP is on record in support of the Health Insurance Association of America (HIAA) plan to enact small market reforms. We believe that those who actively block effective incremental changes because they are holding out for the "big fix" which may still be years away are being unfair to those who could be helped now by more modest, yet important changes.

VII. MANDATES

Obviously much has been said about mandates in the context of health care reform. For some of those committed to an employer-based system and to universal access as a national public policy, mandates seem the only logical option to effectively expand access, especially to the working uninsured. We would disagree.

Because APPWP members provide quality health benefits to their full-time employees and their families, most proposed mandates would have only a modest effect on most of our members. However, the employer community has always opposed new mandates because they don't want the government telling them what they have to do, and because mandates, though they may start out modestly, quickly grow in expense due to expansion and complex regulation. No matter how minimum or modest a health benefit mandate would begin, one only has to look over the vast array of state mandates to see how difficult it is for legislators to keep a mandate to a true minimum. Furthermore, any mandate would have to be designed to complement and sustain the private, employer-based system. We have seen no pay or play proposal as yet that would accomplish this objective.

We have also stated that while we oppose mandates, we would find a coverage or "offering" mandate less onerous. Under a coverage mandate, employers would be obligated to provide an unspecified, perhaps actuarially-equivalent benefit package for his or her employees. This unspecified package provides the employer the flexibility to design a program to best suit his or her workforce. Under an offering mandate, an employer would be mandated to merely offer access to a group health plan, with no requirement to contribute, other than minimal administrative expenses. Such an approach can be found in H.R. 3410, recently introduced by Rep. Barbara Kennelly. The APPWP will study closely and debate all these mandate options.

We must emphasize again, any mandate would have to be carefully designed so as to preserve and strengthen the private sector system, not work to undermine or sap its viability. It would have to include by design, incentives and safeguards that would inhibit "dumping" of private employees into the public plan. We fear that the play or pay proposals we have seen thus far would provide a slippery slope to national health insurance, which we cannot endorse. Finally, while most mandate proposals include certain incentives and cushions to small employers, as they must, the problems of large employers with similar problems—highly mobile, low income, short-term employees—must also be recognized and dealt with.

We still believe that all efforts for voluntary expansion through greater incentives and cost containment, as well as a restructured Medicaid, should first be exhausted before any form of mandate be contemplated.

VIII. CONCLUSION

The APPWP represents the most experienced and committed benefits professionals from all across the policy spectrum. If we can reach consensus on some of these key issues of rate regulation, spending targets, taxes, and mandates, then we trust that the Congress can do so as well. To bring that time closer, we suggest that the President of the United States call for a health care summit, bringing together all the key stakeholders and payers and wring from that disparate assemblage a commitment and a consensus to make the needed improvements to our health care system. We also need political leaders who will be honest with the American people about the burdens of reform and how they must be shared equitably by all. We can no longer promise the American people open-ended health care for which they pay little or nothing. Reform of our system will not come easy or cheap.

We must have policy makers who will be honest with the American people about the costs and burdens of reform. For most Americans, reform proposals now under consideration may mean such changes as higher unemployment, higher taxes, lack of freedom of choice, rationing of care by age or degree of illness, queues for certain treatments and procedures, and higher out-of-pocket expenses. For those without coverage, however, reform should mean improved access to care. But we cannot mislead the American people and tell them that they will be issued a health card with which they can go get any medical care or service they want or believe they need without additional substantial cost to them, and to our society's ability to support other basic needs. That kind of thinking actually got us in the mess we're in now. It's time to tell the truth.

STATEMENT OF BLUE CROSS AND BLUE SHIELD OF MARYLAND

My name is Carl J. Sardegna, and I am Chairman and CEO of Blue Cross and Blue Shield of Maryland, Inc. I am submitting this written testimony for inclusion

in the hearing record on health care reform, of the United States Senate, Committee on Finance.

It is a great pleasure to have the opportunity to discuss health care reform and a market-based solution that I believe has real promise. I would like to thank the Committee on Finance for holding its hearings on health care reform because public debate about the fundamental requirements for true reform is essential if we are to resolve the critical problems with our health care system.

In Maryland, the House Economic Matters Committee under the leadership of its Chairman, Delegate Casper Taylor, has taken the initiative and pushed health care reform to the forefront of public debate. We have, for the first time, a real opportunity for fundamental reform.

As this Committee knows only too well, growing concerns about health care costs and poor access have stimulated the development of multiple health care reform proposals.

Proposals from members of the House and Senate, medical specialty societies, public interest groups, and organizations such as the Heritage Foundation, to name a few sources, are piling up on the p· blic policy table at a rapid clip.

Yet when all of these proposals are distilled, three models stand out:

—"single payer" in which the government runs the health care system in one way or another;
—"play or pay" which mandates employer financial contributions to expand access; and
—"consumer choice" which involves the use of tax credits or vouchers to give consumers a direct financial incentive to behave as responsible buyers of health care—or in other words, to put market incentives into the health care system.

I support the version of the Consumer Choice approach which is being actively considered in Maryland as a statewide demonstration. I believe it can work in Maryland, and I believe it offers a model for the nation as well, because unlike the other approaches, it achieves four critical health care reform goals:

First, **it provides universal and continuous access** for all to standard insurance benefits without regard to employment or health status;

Second, **it moderates costs** by using competition to pressure insurers and health care providers to operate efficiently, and to put more purchasing power in the hands of consumers;

Third, it **is budget neutral and uses an equitable financing** methodology; and

Fourth, **it preserves what is good about our system**—a system that fosters competition and innovation, encourages the development of technology, and allows Americans to keep what they value so highly, the right to choose doctors they trust, without long waits for care.

All four goals must be achieved if we are to see true reform in this country. The piecemeal solutions of the past have simply not worked. In fact, they have exacerbated our problems.

I contend that neither the "single payer" nor the "play or pay" approach offer viable solutions for "fundamental reform. The "single payer" model forces cost control through global budgeting, by price regulation and by capping the volume of services. As in every other country where this has been tried, the inevitable result is rationing and waiting lines.

I also believe that this model will discourage innovation in the development of new medicines and technologies. Furthermore, consumer research repeatedly shows that while most Americans want reform they do not want a system run by the government.

The "play or pay" approach leaves one-third of the uninsured population uncovered, including many unemployed and part-time workers. This model also puts an enormous financial burden on employers, without offering them any hope of reducing their health care benefit expenses and becoming more competitive.

Finally, both approaches would require a substantial infusion of funds into a system that already costs too much, at a time when the country is staggering under the weight of our deficit. Neither approach 'would encourage competition or put market forces to work to moderate cost increases.

It probably goes without saying, that one of the reasons that health care costs are consistently higher than the Consumer Price Index is that the end users of the health care services, consumers, and those who order health care services, health care providers, have been shielded from the economic consequences of their choices by insurance.

Imagine what would happen if everyone in this country had a food card for the price of an annual premium, that provided access to any grocery store, and covered costs, with a deductible or co-pay, of whatever food products the store manager recommended. The lack of market place incentives would surely result in a steady escalation of food prices.

Simply put, we need market place incentives in the health care system that put the consumer in the driver's seat. The Consumer Choice Health Plan being debated in Maryland does that. In this model:

1. **Every individual, including those currently served by Medicaid, and excluding only those already covered by Medicare, would purchase a comprehensive standard insurance plan** from a qualified carrier. Purchase of supplemental insurance would be optional.
2. **Consumers would purchase the standard insurance from their employers or shop on the open market.** Those who are unemployed could obtain insurance from designated public agencies or brokers.
3. **The standard insurance would be similar to comprehensive plans** available on the market today and would include preventive as well as acute care benefits.
4. **Issuance of the standard insurance would be guaranteed and renewable** without regard to health status or claims experience. In other words, no more exclusions on pre-existing conditions, and no more loss of insurance when you change jobs.
5. **All individuals,** not just those at lower income levels, **would receive a refundable tax credit or voucher** to use toward the purchase of the standard insurance.
6. **The tax credit would be progressive** and the amount would be geared to pay 100% of the estimated cost of the standard plan for those below the poverty level, and scaled down to where it would provide 50% of the cost of the standard plan for families with incomes over $100,000. (See Table 1).
7. **Health care benefits received by individuals will be treated as taxable income and the deduction for out of pocket medical expenses will be eliminated.** Today, high income individuals benefit from a hidden tax subsidy because they do not pay taxes on the value of health care benefits paid by their employers. The value of this subsidy is $65 billion nationally and $1 billion in Maryland.

It is important to note that the value of the progressive tax credit is calculated to offset taxes in a way that families earning less than $50,000 will break even or gain financially from this proposal, assuming the employer does not contribute anything to the plan. If the employer holds the employee harmless, which I believe most will do, even those earning $100,000 or more will break even (See Tables 2 and 3).

8. **The workplace would remain the focus** for purchasing health care benefits for most consumers. All employers would offer a standard and a supplemental insurance plan to their employees, but financial contribution to the plan would be optional, just as it is today.
9. **Employers would all pay a 4% payroll tax as their only mandatory contribution to health care benefits.** This is significantly less than the 8 to 10% of payroll they are paying today. For those employers who are not contributing today, it would provide an affordable way for them to participate.
10. **Consumer protection would be built in.** In order to do business in the state, carriers would have to be qualified. To be qualified they would have to offer the standard insurance, meet certain financial criteria including caps on administrative expenses, and be proficient in managing the cost and quality of care.

Let's look at how this would work in an employment setting. First, an employer would arrange through a qualified carrier or broker to offer a standard and supplemental plan at group rates to its employees, and decide the level of its financial contribution.

An employer who wanted to maintain the same benefits plan that was in place before consumer choice, would already be financially ahead of the game, because the cost to the employer to fund the identical plan will be reduced by the amount of employee tax credits now available to defray the cost.

We estimate that employer savings will be between $500 and $1,000 per employee, depending on the level of health care benefits currently provided (See Table 4).

Employer savings could be passed on to employees as increased wages, invested, or retained as earnings or profit.

Employees, knowing the value of their tax credit, and how much the employer would pay (in other words, how much they have to spend), would decide whether

to purchase the standard plan from the employer or search for a better deal on the open market, as well as whether to purchase any supplemental benefits.

Comparison shopping would be greatly simplified because the standard insurance benefit would be just that—standard.

When consumers know how much money they have to spend and can truly comparison shop, they will be far more value conscious. Insurers will be forced to offer insurance products at or below the target price associated with the full value of the tax credit to stay in business.

Just as an aside, I can tell you from our experience at Blue Cross and Blue Shield with consumers who purchase insurance directly, that they are very value conscious and they put enormous pressure on us to deliver good insurance values.

Under the competitive pressure generated by the Consumer Choice Health Plan, qualified carriers will in turn contract with health care providers in organized delivery systems that can demonstrate the ability to deliver quality care in an efficient and cost conscious manner. This is managed care in action. Obviously, selective provider contracting is happening today, but it will intensify and expand and become much more sophisticated than it is today.

Consumer demand for value will also put enormous pressure on the entire system—health care providers and insurers alike—to find ways to eliminate waste in the system.

The Consumer Choice Health Plan also assumes the adoption of a uniform claim and installation of electronic networks throughout the state to eliminate the cost and burden of today's paper-bound processes. The Plan also assumes that there will be caps on administrative expenditures.

One of the cornerstones of the Consumer Choice Health Plan is its funding mechanism. There is enough money in the system today to expand basic insurance to all and to fund the tax credit. The funds just haven't been allocated equitably. The five principle sources of funds are as follows:

1. **Individual income taxes** associated with the elimination of the tax exclusion for health care benefits as well as the deduction for out of pocket medical expenses.
2. **A 4% employer payroll tax.** As I said before, employers who contribute to health care benefits today pay between 8 and 10% of payroll.
3. **Increased corporate tax revenues** on any increased profits earned to the extent that employee tax credits reduce the level of employer expenses for health care benefits.
4. **Federal and State public funds** currently spent for the acute care part of Medicaid and other public health programs.
5. **Uncompensated care** dollars no longer need to cover hospital bad debt.

It all adds up to a program which is budget neutral. (See Table 5) It can be done. The math works for Maryland and it works for the nation.

Can the Consumer Choice Health Plan be successful? Yes, I believe it can. The current Federal Employees Program is somewhat structured like the Consumer Choice Health Plan, in that it offers a specified amount of financial contribution which is known to Federal employees together with wide choice of plans.

I believe that the success of the FEP program in moderating cost increases can be attributed in large part to the design which gives consumers a clear role in making their purchase decisions.

As you can see, this proposal varies in significant ways from that proposed by President Bush and somewhat from that proposed by the Heritage Foundation.

The Bush proposal provides a tax credit for individuals at the lower income scale, but offers no explicit funding mechanism. It also continues the tax deduction for employer based insurance which insulates consumers from the market.

The Heritage proposal goes much further, by repealing the tax exclusion for health care benefits, and imposing an individual mandate, as well as expanding the tax credit to a wider income band. However, the Maryland Plan relies much more heavily on employers to participate through the requirement that all employers offer insurance as well as help finance the tax credit through the 4% payroll tax.

In conclusion, I believe that the strength of the Maryland Consumer Choice Health Plan is that it achieves all four reform goals in an integrated way. It provides universal access to a standard benefit which eliminates the need for a separate public program for acute care Medicaid.

The Consumer Choice Health Plan brings competitive pressures into the system to control costs. It equitably reallocates funding so that it is budget neutral. And it preserves what is good about our system.

Obviously there are aspects of this proposal that are controversial and details that are subject to further discussion. But I believe that the principles inherent in the

Plan are solid and equitable. The truth is that fundamental reform requires everyone to give a little to make it work.

If the problems of the system are looked at from an integrated rather than a piecemeal perspective, I think we will have a real shot at success.

At this point, Cas Taylor and others are working hard in Maryland to implement the Consumer Choice Health Plan as a statewide demonstration.

We strongly believe that experimentation at the statewide level is the way to go because of the dramatic changes that potentially could occur with a significant part of the national economy under a permanent change of such scope.

We urge you to consider a tax credit approach like the Maryland Plan as a viable alternative in reforming our health care system. Additionally, we urge you to adopt legislation which provides the necessary waivers and funding for statewide demonstrations.

Thank you for the opportunity to comment.

TABLE 1

PROGRESSIVE TAX CREDIT

Family Income	Tax Credit	% of Premium
$0 - $13,359[1]	$3,400	100
$13,360 - $26,718	$3,060	90
$26,719 - $49,999	$2,890	85
$50,000 - $99,999	$2,210	65
$100,000 and above	$1,700	50

Source: Center for Health Policy Studies
Columbia, Maryland

[1] Poverty level for family of four.

TABLE 2

FINANCIAL IMPACT OF CCHP ON A REPRESENTATIVE EMPLOYEE
(Salary $45,000; Family Coverage)

	Consumer Choice	
	No Employer Contribution	With Employer Contribution to Hold Employee Harmless
TOTAL AVERAGE COST[1]	$3,400	$3,400
Tax Credit - (85%)	$2,890	$2,890
Contribution to Health Coverage Employer Employee	 --- $510	 $510 ---
Federal and State Tax Liability[2]	$682	$779
Net Cost to Employee[3]	$1,172	$779
Current Cost to Employee[4]	$1,200	$1,200
Savings to Employee[5]	$28	$421

Source: Center for Health Policy Studies
Columbia, Maryland

[1] Estimated average cost of standard managed care benefits package (Assumes cost of standard benefits package is reduced 15% through managed care and benefit design.)

[2] Marginal tax rate of 27.9% on value of tax credit plus employer contribution.

[3] Total of employee contribution and tax credit.

[4] Average employee contribution to current health care premium.

[5] Difference between current cost and net cost.

TABLE 4

FINANCIAL IMPACT OF CCHP ON A REPRESENTATIVE EMPLOYER
(50 Employees; $1,350,000 Payroll)

		Consumer Choice	
	Current	With Employer Contribution	No Employer Contribution
Employer Premium Contribution	$140,000[1]	$25,500[2]	N/A
Reduction in Premium Contribution (or "Gain")	0	$114,500	$140,000
Maximum Corporate Tax on "Gain"[3]	0	$31,144	$38,080
Payroll Tax of 4%	N/A	$54,000	$54,000
Net Cost to Employer	$140,000	$110,644	$92,080
Net Savings to Employer	0	$29,356	$47,920

Source: Center for Health Policy Studies
Columbia, Maryland

[1] 10.4% of payroll ($2,800 per employee)
[2] 1.9% of payroll
[3] 34% of 80% of gain in revenue to employers

TABLE 3

FINANCIAL IMPACT OF CONSUMER CHOICE HEALTH PROGRAM ON REPRESENTATIVE FAMILIES

	Net Cost Impact	
Family Income	No Employer Contribution	With Employer Contribution
$12,000	1,200	1,200
$25,000	422	713
$45,000	28	421
$75,000	(675)	156
$100,000	(1,100)	(12)

Source: Center for Health Policy Studies
Columbia, Maryland

TABLE 5

CONSUMER CHOICE HEALTH PROGRAM
Funding of Tax Credit in Maryland
(Millions)

TAX CREDIT COST		$4,740
INCREASED INDIVIDUAL TAX REVENUE[1]	$1,043	
PAYROLL TAX OF 4.0%	2,600	
INCREASED EMPLOYER TAX REVENUE[2]	72	
REALLOCATED FEDERAL/STATE MEDICAID DOLLARS[3]	345	
REALLOCATED HOSPITAL UNCOMPENSATED CARE DOLLARS AND OTHER REVENUE SOURCES	280	
TOTAL FUNDING SOURCES		$4,740
STATE BUDGET IMPACT		0.0

Source: Center for Health Policy Studies
Columbia, Maryland

[1] @ 22% Rate (Federal and State combined)
[2] @ 34% Rate of 80% of "gains" (Resulting from reduced premium cost)
[3] Based on 1990 Medicaid data

STATEMENT OF THE CONSUMERS UNION

Consumers Union[1] appreciates the opportunity to present our views on the need for major reform of the American health care system. Few topics have so dominated our concerns as the failure of the health care system to accommodate all citizens. Consumers Union has supported the principle of extending access to high quality health care to all Americans for over 50 years. In 1939, Consumer Reports noted that forty million Americans received inadequate medical care and called for enactment of the Wagner National Health bill, which would have been a "cornerstone for a national health program."[2] In 1946, Consumer Reports supported the Wagner-Murray-Dingell Bill, which would have established Federal compulsory health insurance.[3] In 1974, Consumer Reports published a comprehensive comparison of five proposals for "national health insurance" and established five goals that a national health insurance plan must meet to serve the consumer interest.[4] Consumer Reports published a 2-part series, "The Crisis in Health Insurance," in the August 1990 and September 1990 issues. Most recently, our July 1992 article "Wasted Health Care Dollars" concludes that $200 billion dollars are wasted every year on unnecessary medical procedures and administrative costs.

There are four main points in our statement:

—The health care crisis affects everybody in this country, not just the roughly 15% of the population that lacks health insurance.

—We need fundamental reform of our health care system. Addressing the symptoms alone would lead to new problems in the future.

—A single payer system is the only solution that can achieve the twin goals of universal access and cost control, by exploiting the substantial savings in administrative costs and reallocating these dollars to provide access to health care.

—Critics of the Canadian health care system present a distorted view of the situation with regard to rationing, queuing, development of innovative technology. The Canadian system works well, and is well-liked by Canadians.

HEAVY TOLL OF THE CRISIS, AFFECTING VIRTUALLY ALL AMERICANS

1. The health care crisis affects everybody in this country, not just the roughly 15% of the population that lacks health insurance. It takes a heavy toll especially on the middle class—through "job lock," inordinately high premiums, and the lack of access to health care.

Some people argue that Congress should not overhaul the health care system because so much is going right, and that the uninsured represent a relatively small percentage of Americans. But this viewpoint distorts the reality that **all** Americans are at risk, even those of us lucky enough to have employer-provided coverage today. **We are all at risk** because a major illness or accident could lead us to lose our health insurance or could lead to an unaffordable increase in premium. Our August 1990 article told the story of David Curnow, formerly a partner in a San Diego law firm. He was injured in an accident, when (while riding his bicycle) he was struck by an uninsured motorist. While his insurance carrier paid most of his bills (which totaled nearly ($250,000), he has considerable out-of-pocket costs for the home-health aide services he needs every day. But before long, his health insurance benefits will run out. Eventually he will qualify for Medicare because of his disability, but he will be unable to get coverage for expenses not covered by Medicare. If he is able to return to work, it is not very likely that he will find a firm that has an insurance company willing to accept the health risk he poses.

We are all at risk of suffering "job lock" because of concerns about our inability to switch jobs because of the inability to get health insurance through a new employer. "Job lock" can occur for a variety of reasons: a pre-existing condition clause

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[1] Consumers Union is a nonprofit membership organization, chartered in 1936 under the laws of the State of New York to provide information, education, and consel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of *Consumer Reports*, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants, and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports*, with approximately 5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2] "The Wagner Bill & Mr. Gannett," **Consumer Reports**, April 1939, p. 20 and "By Popular Demand," **Consumer Reports**, February 1939, p. 32.

[3] "Bureaucracy in Medicine?," **Consumer Reports**, April 1946, pp. 110–111.

[4] "National Health Insurance; Which Way to Go?" **Consumer Reports**, February 1976, pp. 118–124.

in a prospective employer's insurance could be burdensome because it precludes coverage for expensive needed care; prospective employers might not have any health insurance benefit; employees might face high premiums if the prospective employer either has a high cost policy or requires a large percent of the premium to be paid by employees. The **New York Times** recently reported that three in ten Americans say that they or someone in their household have stayed in a job they wanted to leave mainly to keep the health benefits. "Job lock" was a major concern for both people with low incomes (22% of adults with household income under $15,000) and for people with middle and high incomes (36% of adults with household income between $15,000 and $30,000; 34% of adults with household income between $30,000 and $50,000; and 18% of adults with household income over $50,000).[5] The extent to which concern about health insurance is stifling the mobility and no doubt motivation of workers in American companies is truly alarming.

We are all at risk if spiralling health care costs lead our employers to either drop health insurance coverage or cut back benefits. Consumer Reports told the story of a small employer (an eight-employee TV repair shop) in Bakersfield, California that could no longer afford to pay half the premium for employees' health coverage. Its employees had to pay the full premium for coverage that doubled in price in 1 year, with premiums for one employee (whose wife had had cancer surgery) of over $10,000 per year. Over half of the non-elderly population without health insurance are working adults. Health conditions of some employees, like Kay Nichols (who at age 38 has glaucoma) lead employers to be either locked-into existing health insurance policies (unable to shop around for a lower-priced policy) or to face difficult-to-accept exclusions for new policies.

We are all at risk if our employer requires us to pay an increasing share of the premium. In 1984, Hewit Associates, a benefits consulting firm, found that 37 percent of large employers paid full premiums for their workers. By 1988, only 24 percent provided these benefits. 48 percent of the low wage members of the Service Employees International Union (whose members are hospital workers, janitors, and government employees) were offered insurance but turned it down because they could not afford the premiums.

NEED FOR FUNDAMENTAL REFORM

2. We need fundamental reform of our health care system. Addressing the symptoms alone would lead to new problems in the future.

A variety of types of legislation has been introduced—ranging from modest reforms of the small group market to more comprehensive "pay or play" proposals to fundamental reform of the health care system through a single payer system. Consumers Union believes that only through establishment of a single payer system will we meet our goals of universal access and cost control.

I would like to comment on the "pay or play" approach. The key drawbacks of a "pay or play" approach are:

—By continuing to rely on the 1500 or so insurance companies, this approach loses the opportunity to tap the $67 billion **per year** administrative expenses (approximately 10 percent of the nation's health care bill) that could be used to pay for health care. (The Medicare program provides support for the principle that public programs are low in administrative costs, with the percent of Medicare revenues spent on administration between two and 3 percent.)

—While "small group reforms" would restrict insurers' ability to charge risk-based premium differentials, there is no getting around the fact that insurance companies will profit by finding new ways to compete in this marketplace. It is difficult to predict exactly where this will lead, but with an eye on profitability driving the system, there may well be new means of excluding undesirable risks and new marketing strategies.

—This structure could cede the relatively poor risks to the public program (which will consequently appear to be relatively high cost) and allow the private sector to cream the best risks. This will be the case when companies compare their costs of participation in the public program with the costs of private insurance; those companies whose private health insurance would exceed the 9% payroll tax [1993] of the public program are most likely to sign up for the public program.[6]

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[5] Erik Eckholm, "Health Benefits Found to Deter Job Switching," **New York Times**, September 26, 1991.

[6] Relatively high average-wage employers are less likely than low average-wage employers to join the public system. To the extent that low-wage employers employ a relatively young work force, this will help decrease the adverse selection into the public program. It is difficult to predict with precision the risk distribution in the public program.

—Americans are seeking a health care system that treats people fairly and they are seeking a system that is relatively easy to understand and to use. While pay-or-play proposals do take some steps to simplifying the market through use of uniform claims forms, there is no way to get around the fact that the proposals are extremely complicated and hard for the average consumer to understand.

A SINGLE PAYER SYSTEM CAN ACHIEVE TWIN GOALS: ACCESS AND COST CONTROL

3. A single payer system is the only solution that can achieve the twin goals of universal access and cost control, by exploiting the substantial savings in administrative costs and reallocating these dollars to provide access to health care.

We believe that Americans would be well served by a single-payer health care system. With careful planning and adequate funding, our country could build on the Canadian experience and could assure that all Americans have timely access to high quality medical care, as well as access to beneficial innovative technology. A single payer health care system offers a huge savings of administrative costs. The General Accounting Office estimates that if the United States adopted a Canadian-type of single payer system, we would save $34 billion in insurance overhead and $33 billion in hospital and physician administrative costs (1991 figures).[7]

In order to better understand the Canadian health care system, I contacted—by phone and by letter—some prominent Canadian doctors and health policy researchers. My aim was to explore and better understand possible failings of the Canadian system. What I encountered was universally positive and supportive of their system. Below is a sampling from their letters:

"Our universal health insurance plan is one of government's most popular and publicly approved programs."[8]

"It would be very difficult to generalize on the public perception in Canada of the extent to which queuing for surgery is a problem. There have been very vocal interest groups dealing with cardiac surgery for example, but polls have shown that there is a high level of overall satisfaction in Canada with the health care system."[9]

"There has so far been very little pressure to modify the health care system by allowing private insurance. Polls show that Canadians are highly satisfied with the existing system and indeed they also show considerable resistance to any possibility of a two-tier system."[10]

Consumers Union supports adopting a single payer health care system and tapping the substantial administrative cost savings to expand access to health care and to expand coverage to eventually include long-term care for all Americans. Consumers would continue to have freedom of choice of health care provider. It is sound public policy to reallocate the 67 billion dollars that could be shifted from administrative costs to expand health care coverage and improve health care.

THE CANADIAN SYSTEM WORKS WELL AND IS WELL-LIKED

4. Critics of the Canadian health care system present a distorted view of the situation with regard to rationing, queuing, development of innovative technology. The Canadian system works well, and is well-liked by Canadians.

Rationing. Some critics of the Canadian system charge that it results in rationing of health care. It has almost become a cliche that health care is rationed by price in the United States, with the insured getting high-quality health care and the uninsured lacking access to adequate health care. But the situation in this country is more complicated than this. Dr. C. Everett Koop recently showed that emergency room care **in the United States** is already rationed to some degree because of a mismatch of capacity with need. And the state of Oregon is leading the way with a proposed experiment of rationing of health care services for the poor, in order to provide access to a broader array of effective health care services for the near-poor. Large-scale rationing of health care **in the United States** will become a reality **unless a major reform of the health care system is enacted.** More and more companies will follow the developing trend of cutting back on their coverage of high cost

[7] "Canadian Health Insurance: Lessons for the United States, Report to the Chairman, Committee on Government Operations, House of Representatives, General Accounting Office, June 1991, p. 63.

[8] Michael B. Decter, Deputy Minister, Ministry of Health, Ontario, Canada, letter of October 11, 1991.

[9] Dr. Charles J. wright, Vice President, Medical, Vancouver General Hospital/British Columbia's Health Sciences Centre, letter of August 12, 1991.

[10] Dr. Adam L. Linton, President, Ontario Medical Association, letter of August 16.

procedures if costs are not contained. It is crucial that Congress address this very real need to take steps to control costs because the cost spiral will lead to very real rationing in this country. The best way that Congress can **avoid** inappropriate rationing is to adopt a single payer system, with application of the findings of outcomes research, so that we can not only reallocate the $67 billion of administrative costs in the present system to provide health care, but in addition we can assure that our dollars are spent on effective procedures that benefit the patient.

Queuing. Similarly, critics of the Canadian system charge that Canadians must wait in long lines to receive care. When I contacted several doctors and researchers in Canada to explore this charge, I met with a universal response that this concern is overblown. First, it is important to separate the issue of supply of health care personnel and technology from the issue of how the care is paid or. Instituting a single payer system alone will not lead to queues, considering the fact that the U.S. health care system currently has excess capacity. Second, Canadians do not have to wait for emergency care. Third, waiting lines typically occurred when patients requested a certain doctor or hospital. One of the strengths of the Canadian single payer system is the freedom consumers have to select the doctor they want; one result is that Canadian consumers—like American consumers—may have to wait to get treatment by the doctor of choice. We should not talk about "queues" without acknowledging that our system often has them as well. Fourth, in an efficient health care system, some waiting time is needed in order to use equipment and personnel efficiently. The alternative to modest waiting times is excess capacity that results in out-of-control health care costs and possibly unnecessary treatment. "The real issue for any health care system dedicated to universal access is not that queues exist for some services, but rather how best to measure, monitor, and manage them," concludes Dr. C. David Naylor in his recent article about queues for open-heart surgery in Ontario.[11]

I would like to share with you some comments on the subject of waiting lists from Dr. Charles Wright of Vancouver General Hospital. The comments demonstrate the need to look at the issue of waiting lists from the perspective of managing waiting lists and developing optimum waiting lists, instead of dismissing a single payer system because of an irrational fear of waiting lists:

> It would be very difficult to document the effect of waiting lists on health consequences, but informed opinions suggest that they are minimal. It is necessary to remember that a waiting list is absolutely essential in order to run an efficient elective surgical system in which patients are treated only for appropriate indications. The debate comes as to how long an appropriate waiting list should be. So many elective surgical procedures are 'judgmental'. That is, there is not a switch (contrary to what the general public often believes) which says that you either do nor do not need surgery. It is a question of balanced judgment. Surgery is often one among many alternatives, and the degree of disability at which the risks of death and complications of surgery become justifiable is very much a matter of opinion. This applies to some of the largest volume and cost items in our repertoire, for example, major joint reconstructive surgery, cardiac surgery, urological surgery, plastic surgery, etc. What is often not realized is that most surgery falls in a grey area where judgment is required and where the indications for operation may be more or less strong.[12]

I believe that when more and more Americans realize that their family, their spouse, their children are at risk of being left out of the line for health care in the United States, that they will be willing to accept a system that treats them fairly and allows them to join the line for health care in a rational health care system.

Innovative Technology. Critics of a Canadian type of health care system argue that if America adopted it, Americans would have less access to innovative technology. There are two issues here—the question of development of new technology, and the accessibility of the technology to consumers across the country. With regard to the development of new technology, I do not believe that whether a country has a single payer health care system is the dominant factor in whether it is a leader in the development of new technology. One issue is the availability of venture capital. Another factor is that pharmaceutical companies and medical technology development companies operate on a global basis and consider worldwide demand for their products. The United States, for sure, has been the location for the development of new technologies. But it does not presently have a monopoly on the develop-

[11] C. David Naylor, "A Different View of Queues in Ontario," *Health Affairs*, Fall 1991, p. 111.
[12] Dr. Charles J. Wright, Vice President, Medical, Vancouver General Hospital/British Columbia's Health Sciences Centre, letter of August 12, 1991.

ment of innovative technology, as demonstrated by the fact that extracorporeal shock wave lithotripsy (for treatment of kidney stones and gallstones) was developed in Germany.

The second key issue is the accessibility of innovative technologies to citizens of a country (referred to in the literature as diffusion). There is no question about the fact that if you compare the number of people served by unit of selected medical technologies (e.g., open-heart surgery, cardiac catherization, organ transplantation, radiation therapy, extracorporeal shock wave lithotripsy, magnetic resonance imaging), there are far fewer people per unit in the United States than in either Canada or Germany.[13] But as researcher Dale Rublee points out, "The differences can be interpreted to suggest overprovision in the United States rather than underprovision in Canada or Germany." In Canada and Germany, some efforts have been made to limit new technologies to help assure that they are cost-effective. For example, MRI's are prohibited outside of hospitals in Canada. The important lesson for the United States is not that we should seek to emulate Canada's pattern for diffusion of technology, but that a conscious effort should be made to take cost-effectiveness into account in making decisions about location of expensive medical equipment. In the long-run, this will benefit all of us.

HOW TO GET FROM HERE TO THERE

We believe that there is growing awareness that our health care system needs a major overhaul. But we also acknowledge that in order to achieve the type of reform we support, Americans need to be strongly behind the proposal. The first step is for Congress to acknowledge the need to go beyond "small group reform" and other small-scale reforms of the system, and make a commitment to developing a blueprint to achieve both universal access and cost control through a single payer system. We need not only political leadership from Congress (and hopefully at some point the Administration), but we also need continued education efforts from groups like Consumers Union.

Once the commitment is made to achieve universal access and cost control through a single payer system, the question of how to phase in a program will need to be considered. We urge you not to turn to "pay or play" as the ultimate solution, for reasons outlined above. Instead, we urge you to consider phasing-in the program by starting, for example, with doctor coverage, then hospital coverage, home care services, and nursing home coverage. If you choose to phase-in population groups (e.g., children, pregnant women, people 60 to 65 years old), we urge you to do so only as part of a larger plan that by design will include everybody on a fixed schedule, for fear that we repeat the experience of the 1960's, when only the poor and the elderly's needs were addressed.

In conclusion, I would like to thank the Committee for giving Consumers Union the opportunity to present our views. We look forward to working with you to make high quality health care a reality for all Americans.

STATEMENT OF MELANIE D. GRAHAM, M.D.

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM HOSPITAL,
Birmingham, AL, July 21, 1992.

Dear Members of the Committee on Finance: This letter is in regard to the new physician differential reimbursement rates imposed by Medicare. I am a senior resident in the field of Radiation Oncology and am about to enter private practice. I am directly affected by the new Medicare physician fee schedule and am opposed to it for many reasons. The first of these is that this is an unfair practice which discriminates against young physicians. As young physicians, we are in a great deal of debt after supporting ourselves through medical school and residency with the help of loans. Yet because we are new physicians, we will be paid less even though we are working as hard if not harder than established physicians in the community. I feel that as newly trained physicians, we actually have more to offer in terms of knowledge of the most recent developments in our respective fields. Therefore, I do not feel that we should be reimbursed less. Our patients, however, may see that there is a differential reimbursement rate and may confuse this with a lower quality of care.

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[13] Dale A. Rublee, "Medical Technology in Canada, Germany, and the U.S.," *Health Affairs*, Fall 1989, p. 180.

I fully support the Medicare system and I believe that the elderly and disabled deserve quality medical care. However, with the reductions made under the radiology fee schedule and now the additional reductions under the new physician fee schedule, it may substantially decrease my ability to accept Medicare as payment in full. I hope that this will not be the case because I feel that it will be the patient in the end who suffers.

Thank you for taking the time to consider my opinion on this issue.

Sincerely,

MELANIE D. GRAHAM, *M.D./tch,*
Department of Radiation Oncology.

STATEMENT OF THE GRAPHIC ARTISTS GUILD

Mr. Chairman and Members of the Committee, the Graphic Artists Guild greatly appreciates the opportunity to submit testimony in favor of single payer health care legislation. The Graphic Artists Guild is a national advocacy organization representing professional illustrators, graphic designers, cartoonists, surface and textile designers, computer artists and other creators. Affordable, quality health care with universal access is one of the top priorities for the Graphic Artists Guild and its 2,700 members. In fact, the Guild's National Board of Directors has unanimously endorsed Universal Health Care legislation (S. 2320 and H.R. 1300) to demonstrate our institutional commitment to a single payer health care system.

Our nation's current health care system hurts each of the members of the Graphic Artists Guild as well the Guild as a not-for-profit organization. Ninety per cent of Guild members are "freelancers," single-proprietorships who must secure their own insurance coverage. Because private insurance carriers arbitrarily "redline" artists and other creative occupations, Guild members are either denied coverage outright or forced out of plans by constantly rising premiums. These rising premiums result in a decline in membership for the Guild, our dominant source of revenue, as well as higher staff costs to remain competitive.

DECLINE IN GUILD MEMBERSHIP DUE TO RISING INSURANCE PREMIUMS

In response to member demands, the Guild has been offering a variety of insurance products to its members for over twenty years. Although the Guild receives no royalties or other income from these offerings, the organization did enjoy a rise in membership from those who needed insurance. However, as premiums for those products rose, Guild membership declined proportionately.

For example, in 1985 the Guild had more than 3,200 members, of which 627 participated in the Theater and Entertainment Industries Group Insurance Trust (TEIGIT), the plan offered by the Guild and underwritten by Connecticut General—CIGNA. Today only 225 participants remain, and Guild membership has declined to 2,700.

CURRENT OPPRESSIVE HEALTH CARE SYSTEM

The Guild sees every dollar paid in health insurance premiums as an oppressive tax, an exorbitant payment for inferior service. In 1985, a single, 35-year old Graphic Artists Guild member paid $1,110.56 for a year's comprehensive coverage with a $200 deductible. Today, a 35-year old single Guild member pays $2,811.60—*a 253% increase!* In addition, the deductible has *increased five-fold to $1,000.* Family premiums rose comparably. For instance, a 35-year old artist with a family of four spent $3,038.56 in 1985 with a $200 deductible per person. However, today it costs $7,854 (again, a 258% increase), the deductible has increased to $1,000 per person and fewer procedures are covered.

We cannot emphasize the regressive effect of the current health care system enough. A Guild family whose household income is $12,000 pays the same $7,854 as the Guild family whose household income is greater than $100,000. Guild members are literally forced to choose between insuring their families against potential medical catastrophes and putting food on the table or paying rent.

In addition, older members who have been paying premiums for years, are now being denied coverage or priced out of existing plans. Private insurance carriers will continue to collect premiums from young and healthy individuals, who require minimal health care. Yet when these individuals reach their senior years, and therefore require more medical care, they are either dropped or priced out of health care plans. Something must be done to remedy this injustice.

CURRENT HEALTH CARE SYSTEMS THREATENS VIABILITY OF THE GUILD AND THE SMALL BUSINESSES OF OUR MEMBERS

Costs for the Guild staff insurance plan have risen comparably. Fringe benefits (including medical, hospitalization and life insurance) reflect 22.5% of total payroll, which is a 27.4% increases over last year. This problem is adversely affecting the ability of small businesses, whether for-profit or otherwise, to remain competitive in the market. As a small business employer, I would gladly pay an additional 7.5% payroll tax that would replace the 22.5% I am now paying to private carriers and Blue Cross/Blue Shield.

To counter the effects of these prohibitive, uncontained health insurance costs, some small businesses (including graphic design firms who rely on freelance artists) are changing the status of their employees to independent contractor. This effectively relieves the small business of the obligation to provide fringe benefits. Of course, this practice carries severe consequences if the Internal Revenue Service determines those workers to be employees.

WE NEED RADICAL CHANGE

The costs for obtaining and maintaining quality, affordable health care are out of control for everyone in this country. Currently, various plans for providing national health care are being debated. Some of these plans still entrench private insurance companies in the "business" of health care, while many don't address the needs of those who are not traditionally employed, such as many artists. *This country need a plan that covers everyone for everything with no out-of-pocket expense and the freedom to choose your own doctor.* We need a single payer health care system.

A single payer system would allow the Guild to focus its marketing efforts on the benefits and services to meet its mission and not focus on insurance premiums. Potential members, with their health needs met, could in turn concentrate on the professional goals.

All Americans have a *right* to affordable, quality health care. In recognition of this, the Graphic Artists Guild National Board of Directors has unanimously endorsed the Universal Health Care Act of 1991, Rep. Marty Russo's (D–IL) H.R. 1300, and its Senate counterpart, Sen. Wellstone's (D–MN) S. 2320. Under these plans, a single, publicly-administered program health insurance program to provide affordable, comprehensive, quality health care to all Americans would be established. The national health insurance program would simplify and streamline the administration and financing of health care. This single universal system would eliminate billions of dollars now wasted on administrative costs. Also, increases in future costs would be controlled through annual budgets and national fee schedules so that health care dollars are spent efficiently and effectively. Meanwhile, consumer choice would be increased through the delivery of services by a greater selection of health care providers—everyone can choose his or her own physician or source of care.

There would be no gaps in coverage and no barriers to care. This means comprehensive benefits for every American—including hospital and physician care, long-term care, prescription drugs, preventive care, dental and vision care, and defined mental health benefits. The government would become the sole health insurer.

Under Universal Health Care legislation, U.S. citizens and legal residents receive a national health card which they would simply show to receive health care from the health provider of their choice. Everyone has the same health plan. This plan would not change when a person changed jobs or moved to a different state. There would be no more discrimination based on age, health, income and employment.

Also, the Guild believes that dramatic savings will be experienced by the health care system due to the fact that the medical costs which are factored into all liability insurance and liability claims will no longer be a consideration in a single payer health care system since everyone is unconditionally covered.

The money to pay for Universal Health Care legislation is the same money currently being spent on health care *except* it will be collected in a fair and equitable manner. A National Health Trust Fund would be established under the Wellstone/Russo bills to collect revenues only to be used for health care expenses. The national health insurance program would be financed through a federal, state and local governments, taxes on corporations and wealthy individuals, as well as an employer payroll tax. Ninety-five percent of all Americans will pay less than they pay now.

The benefits a single payer health care system are obvious. Artists, as well as all Americans, will get the health care they need rather than the health care they can afford. No longer will coverage be dictated by what their insurance company is willing to pay. In addition, our federal and local governments would save billions in unnecessary health care administration.

Artists, united, can help make universal health care a reality. We've proved our ability to succeed in the past, through organized legislative efforts such as the *Artists For Tax Equity (AFTE),* and we're committing similar resources to achieving a single payer health care system. The Guild has drafted a statement to organize *Artists United for Universal Health Care (AUUH),* a coalition to include actors, art therapists, composers, craftsmen, dancers, designers, directors, foundations, graphic artists, illustrators, journalists, museums, musicians, painters, photographers, sculptors, writers and others, united by a common goal: establishing an effective national health insurance program benefiting all Americans.

STATEMENT OF THE INDEPENDENT INSURANCE AGENTS OF AMERICA

Mr. Chairman and members of the Committee, my name is George Stancil. I am a partner in the Cornell Insurance Agency in Grayling, Michigan and Chairman of the Independent Insurance Agents of America's (IIAA) Health Care Task Force. IIAA is the nation's largest insurance agent association, representing over 220,000 agents and their employees throughout the country. I am pleased to have the opportunity to submit testimony to you today on expanding and improving employment-based health insurance coverage.

IIAA has a keen interest in the health care debate for two reasons. First, though our members sell all lines of insurance (predominantly property/casualty), an increasing number of agents are entering into the health care market. The second, and possibly more important, reason for our interest in this issue is that our members are all small business-people. The average insurance agency employs only about ten people, though some can have as many as 200 employees or be as small as a two person shop. Our members confront the same obstacles and frustrations as any other small business in trying to insure their workers.

Earlier this year IIAA developed a health care policy statement which strongly supports market reforms and, if implemented, would vastly improve the employment based system of health insurance. As you know Mr. Chairman, our position closely mirrors legislation you have introduced, the "Better Access to Affordable Health Care Act of 1991" (S. 1872). We commend you and others for offering a reasonable approach to curing a large part of our health care crisis. While IIAA has concerns about the specifics of a few provisions in S. 1872, we strongly support the ideals and goals of this legislation. We look forward to working with you on this legislation and hope that others who may have more ambitious proposals will see that your plan is workable, politically feasible, and a productive first step toward insuring the citizens of this country.

Today in this country there are over 30 million Americans who do not have health insurance coverage and consequently adequate health-care. Of this number, some three-fourths are employed or are dependents of a worker. Estimates have shown that nearly half the uninsured work in a company or office with less than 50 employees. Obviously, the smaller the business, the more difficult it is to provide coverage. Insurance companies have traditionally steered clear of small businesses because they represent a higher risk in proportion to premiums paid. More often than not, however, a small business simply cannot afford the insurance products available to them. It seems clear to us that the prime focus of any legislation on this matter is to make health care more affordable and ultimately, health insurance more accessible.

IIAA strongly believes that cost-containment measures would greatly relieve the burden of health care costs. We support many of the cost containment measures included in your bill: the establishment of a commission to advise on cost containment; and the encouragement of managed care programs and utilization review. The concept of managed care was developed by the insurance industry to trim the costs of full-service medical care. Most agree a basic health care package which includes the use of managed care and/or utilization review would represent a huge cost savings to an insurance program.

Your proposal also calls for the pre-emption of state mandated health benefits. Each state has developed its own blueprint for what every health care policy should include. In theory this would seem both logical and appropriate. The insurance industry is regulated at the state level and IIAA strongly supports state regulation. However, these state mandates no longer resemble the common sense components they once were. In 1972 there were less than 50 state mandates for health coverage across the country—in 1992 there are nearly 1000. While we applaud individual state efforts to trim the burdensome and costly mandates themselves, we fear that the only way to achieve this goal is federal pre-emption. A state-by-state repeal

would most likely last well into the next century. The American people simply cannot wait that long.

As we studied this issue, we found a phenomena with which I am sure you are familiar. Increasingly, doctors, hospitals and other health care facilities devote an ever larger amount of time and manpower to paperwork. Many doctors now have a full-time staff person who just files insurance forms. The administrative costs are passed on to the patient and needlessly raise the cost of health care. Indeed the insurance industry pleads guilty to the explosion in bureaucratic paperwork involved in filing a claim. Filing a claim should not take a degree in advanced form technology. For this reason IIAA strongly supports the use of common forms by all insurance carriers. Familiarity will ease the burden for doctors and patients alike. Furthermore, we would strongly encourage the use of an automated claims system. This concept could be reviewed by your proposed cost containment commission.

Another way to trim the cost of health care is medical malpractice reform. IIAA believes that this is an essential ingredient to any reform package. While some reports show that only 5% of medical costs can be directly attributed to malpractice insurance, the indirect costs permeate the entire health care delivery system—estimates are as high as 25%. The possibility of multi-million dollar malpractice judgments looms over every medical procedure: it raises insurance costs, spawns defensive medical treatments, encourages doctors to leave specialties for fear of litigation, and needlessly increases the cost of equipment used in medical facilities. We recommend the establishment of a qualified "suggested procedure" system by peer review or other commission. A system which allows the injured to recoup losses for medical costs and lost wages should be implemented. Such a system would also limit or cap non-economic damages and tighten the standards for awarding punitive damages.

Over 50% of IIAA's membership is self-employed. As a group, the self-employed have probably fared the worst in the current health care crisis. Large corporations and companies have the ability to acquire insurance because of a larger risk base. More importantly, a large corporation is able to deduct the cost of health insurance supplied to its employees as a business expense. This huge tax advantage allows the big guys to be magnanimous and caring. However, I wonder if they would provide the same benefits if they did not have the tax benefit. The self employed are only able to deduct 25% of the cost of health insurance on their taxes. It is no wonder that so few of these entrepreneurs actually insure themselves. These people need the same incentives as larger companies to provide health care for themselves. We strongly support your proposal to raise the tax deduction for the self-employed from 25% to 100%. We believe, in the long run, this will save money by eliminating uncompensated care and cost shifting.

We believe any proposed solution to the skyrocketing costs of health care and the lack of access to health insurance must include insurance reforms as well. It is a crime that the people who most need insurance—the sick—are the ones who have the most difficulty acquiring it. There needs to be reform in underwriting. Small firms should not be excluded from doing business with an insurance company because of the high risk. A business which provides health insurance must be able to do so for all of their full-time employees. There needs to be guaranteed renewability unless in cases of negligent premium payments. An employee should not be denied coverage because of a prior condition, a practice which has created a new phenomena called "job-lock". Workers now stay in their jobs, not because they can not find better employment elsewhere, but because they would be denied insurance coverage at a new job. Portability of health benefits would help both the workers and the economy.

These insurance reforms would obviously change how the insurance industry does business. To offset the increased risk taken on by insurance companies, a risk pool or reinsurance mechanism must be established in order to maintain and preserve the stability of an insurance program. We believe this risk pool should be funded, in part, by society and not solely by high risk groups.

Any attempt to control costs and make health care more accessible to more Americans must also require responsibility and accountability on the part of the patient as well as insurance programs and health care providers. In this regard, the focus of insurance services should be placed on preventative care: yearly check-ups, inoculations, etc. I note that your legislation adds early cancer detection and flu shots to the medicare package. It is a well accepted fact that early detection of disease is a cost-effective method of serving the patient. In fact, while many believe that insured people waste valuable health care resources by seeking medical care too frequently, we believe the opposite. People who wait to see a doctor or uninsured people who do not receive care until they are in the emergency room end up costing society far more than those who go to a brain surgeon for a headache.

Small steps such as these will help eliminate waste and alleviate the financial burden borne by all who come into contact with the system: doctors, hospitals, patients and insurance companies. Your legislation embodies many of these suggestions and we commend you for your efforts.

While IIAA believes these basic reforms should be enacted, we strongly support maintaining the current system of health insurance and delivery in this country. We believe that your proposal and proposals being offered by other groups, which correct the failures and inequities of this system, is the only practical way in which to address the problem of over 30 million uninsured Americans. By implementing these adjustments and improvements to the employer- based programs currently used, some experts believe nearly half of those currently uninsured would be able to acquire health insurance. Clearly there would still be people without insurance; people who have fallen through the cracks because they are unemployed or between jobs. We see the need for the government to play a role in helping those remaining in the ranks of the uninsured, but strongly contend that a reformed employer-based system will maintain America's rank as the best health care system in the world.

Once again, I thank you for the opportunity to express the position of the Independent Insurance Agents of America before the Committee.

STATEMENT OF THE INTERNATIONAL LADIES' GARMENT WORKERS' UNION

This testimony on single payer health plans is submitted on behalf of the 175,000 members and 140,000 retired members of the International Ladies' Garment Workers' Union. Our members are employed in producing women's and children's apparel, accessories and related products. They live and work in more than two-thirds of the nation's fifty states, as well as in Puerto Rico and Canada.

It is no accident that poll after poll, study after study, town meeting upon town meeting, editorial after editorial, in growing numbers, cry out for change in America's health care system. Change that addresses not only the problems of the uninsured and the underinsured, but basic change under which no one would be just one job-loss or one illness away from loss of health care protection. Change to restructure and simplify an incredibly complex, ineffective and wasteful hodge podge of a nonsystem for financing and delivering health care and technology.

Our nation's health care system is in critical condition. Widespread public and private efforts to contain and manage costs fall far short of their goal to deliver affordable quality health care to all Americans. Double-digit annual increases in health care costs continue to far outstrip the increases in the general cost of living. The United States now spends more on its health care system than any other nation in the world, now over $800 billion annually, much of it to remedy what could have been prevented. The United States is a model for the world medical community in research and technology, yet our health care system, despite its advances and our high spending, is failing miserably in its basic objective: to provide decent and adequate care for all Americans.

The failure of our health care system is evidenced by one of the highest infant mortality rates in the developed world, ranking twenty-first behind such nations as Britain, Canada, Japan, Ireland, Italy, Spain and Germany. In life expectancy, the U.S. ranks sixteenth for females and seventeenth for males. Of the twenty-four member countries of the Organization for Economic Cooperation and Development (OECD), the United States is the only country besides Turkey in which government health care spending is less than half of the total spent by the nation. The government share ranged from 37% in Turkey and 42% in the United States to 95% in Norway, with an OECD average of 76%.

Some thirty-seven million Americans are without health insurance. They include nineteen million employed workers and ten million children. Tens of millions more are inadequetely insured. As costs escalate and good jobs are lost, the number of uninsured rises each day. Even the insured are adversely affected, as the skyrocketing costs of the failing system are continually passed on to them. Many must delay or pass up needed care or preventive measures due to the burden of mounting deductibles and copayments. Often they wind up needing more costly acute. care. All of us live in fear that our coverage will end due to an illness or job loss.

Under proposals for incremental change, the basic failures and inadequacies of the existing system remain intact, while more money is thrown at providers, insurance companies and administrators without any meaningful controls. High administrative costs, waste, fraud, deductibles and out-of-pocket costs persist and major items, such as prescription drugs, continue uncovered. The elderly, the sick and the poor remain in separate inefficient public pools financed by the resentful largesse of those who in no way benefit from these programs. Healthier groups opt for pri-

vate coverage when they are "winners" and readily join the public plan when they are "losers." It is clear that incremental change is a false nostrum—a patchwork approach which would inexorably lead to the perpetuation of existing inequities and costly duplication of efforts. The health care system of our nation is not a game to be played.

In the health care arena, the marketplace cannot be more efficient than public planning and programs. Left uncontrolled, the private sector will inevitably continue to concentrate on profitable paying patients and moneymaking services, abandoning less lucrative services, such as preventive care, and bypassing the less financially endowed or riskier patients, such as the unemployed and the sick. One can expect the wholesale dumping onto the public system of unprofitable services, higher-risk patients and those less able to pay. The cherry-picking of risks will continue and a two-tier system will evolve, with the public system saddled with skyrocketing costs.

COBRA self-pay continuation of coverage is but one example of a failed incremental solution. It imposes costly and complex administration on providers and encumbers the sick and unemployed with high premium costs when they are least affordable. To deal with ever-increasing costs, benefit funds and employers, led by the government, raise deductibles and co-insurance, institute premium copayments and otherwise reduce benefits. None of these actions begin to address the problem; they merely shift costs and exacerbate an already untenable situation.

Small business insurance reform is another false nostrum which will do nothing to contain soaring medical costs. In fact, a GAO report indicates that such so-called reform may actually make health insurance premiums more expensive for some. Using this limited approach to increase accessibility fails to address the basic need for meaningful cost control or increased access to the system. Similar efforts in 43 states have not resulted in any substantial increase in the number of insured workers. To the contrary, it appears that driving up premium costs for a portion of the already insured could actually result in a net decrease of insured Americans.

Malpractice reform, as currently proposed, severely undercuts patient protection in a delivery system which has an abysmal record of self-monitoring or regulation of the quality of health care. Any reform in this area should be based on the establishment of appropriate treatment protocols and regimens which will protect both patients and providers, in addition to curtailing malpractice premium costs.

Within our own union environment, of our fifteen United States health and welfare funds, thirteen suffered cash deficits in 1991, as expenses continued to outrace income. Two funds' reserves were almost totally exhausted. Employer contributions in 1991 covered only 58% of payouts and, after the addition of investment income, still fell far short of benefit costs.

The unabated increase in the cost of providing health care taxes a further toll as many employers, to remain competitive, must close their plants or shift production to low-wage, low- benefit sources, frequently overseas. This is especially prevalent in the labor-intensive industries of our nation, such as the apparel industry. Ours is a highly competitive industry made up of small businesses paying modest wages. Its low wage base produces an oppressive health cost burden, in excess of 15% of payroll. Elsewhere throughout the developed world the cost of health care for all workers is in some part, if not entirely, financed by public funds rather than as a direct addition to wages.

The ailing United States health care system needs serious immediate attention to effect major overhaul, beyond band-aids and aspirin. To achieve real reform and to remedy the failures of our current system, we need not start from scratch, as an attractive working model is already in operation—the Canadian system. Under such a model, the existing United States system of care and network of providers would remain in place. It is only the method of payment and financing that would change to the use of an efficient and simplified universal administrative apparatus. In effect, a single payer would be created.

Our Canadian members and families are enthusiastic about their comprehensive inexpensive health care system. It covers all necessary hospital and medical care. It imposes no deductibles or copayments. Canadians don't forfeit coverage when they-switch or lose jobs. It's there when they are sick. It gets better when they retire. There is a single system covering young and old, rich and poor, sick and healthy, single and married, employed and unemployed. Canadians can use whatever doctors or hospitals they choose and they never ever have to fill out an insurance claim form!! They are never hounded by physicians or hospitals for payment of bills. The Canadian Medical Association and physicians overwhelmingly support the system. Employers are not oppressed by ever-rising double-digit health care costs which impair their ability to compete with foreign rivals or local competitors who don't provide health coverage.

The Canadian system is substantially financed by the federal and provincial governments and administered provincially under control of a public nonprofit organization. It sharply contrasts with for-profit systems.

In the United States, it was reported that the owners of the Hospital Corporation of America made a $2.1 billion profit on their investment as a result of going public, just one example of how for-profit health providers drain money away from health care. For-profit insurance companies make their money not by being efficient, or managing care, but by weeding out the sick and insuring only the healthy. Studies show that, to reduce risks, insurance companies deny coverage to those who work in construction companies, hotels and restaurants, social clubs, doctors' offices, nonprofit organizations, family businesses and the arts, among other occupations.

The American system of private health insurance is wasteful and inefficient. The health insurance industry spends fourteen times as much on administration, overhead and marketing per dollar of claims as does the whole Medicare program. In 1988, the U.S. system spent eleven times as much on administration per dollar of claims as the Canadian system. A Johns Hopkins University study showed that the average time spent by a physician in the United States in administrative work is close to 16% of practice time. This includes filling out forms, filing claims, making follow-up calls, answering questions, and requesting approval for treatments. The number of health administrators is growing three times as fast as the number of doctors in the nation. The U.S. Government Accounting Office has projected that the savings from a Canadian-type system in administrative costs alone would pay for the uninsured and eliminate deductibles and coinsurance.

Every developed nation on the globe, except the United States and South Africa, has some form of national health insurance in place. In all of these countries the people and the governments are more satisfied with their systems than we are. We believe a single payer model to be the most efficient and effective approach. An American model will in many ways reflect our own unique American base and characteristics, but it will draw from the experience of Canada and others, discarding or modifying what doesn't work, adopting what does work, and finishing it off by incorporating the positives of our own experience.

We believe that our nation can and must adopt a single payer health delivery system which provides a single class of care for all, regardless of age, gender, income, family status, health condition, residence or employment situation. The system must be based on prevention, early detection and intervention, including the full utilization of effective new technology. It should eliminate ineffective treatments and unnecessary tests but provide effectual and efficient treatment in a full range of facilities. The system must include full consumer participation and oversight and contain procedures to ensure quality care, true cost containment and accountability.

Our nation needs and wants national health insurance and we need it now! Americans will support a restructured system with universal access to comprehensive quality care, progressive financing, cost containment and administrative simplicity. It can be done. It must be done.

STATEMENT OF MOBILE TECHNOLOGY INC.

Mr. Chairman and Members of the Senate Finance Committee: I appreciate this opportunity to submit my comments about health care cost containment and improvement, as the committee considers various legislative approaches in developing a health care reform proposal.

I am the President and Chief Executive Officer of Mobile Technology Inc. (MTI), headquartered in Los Angeles, California. MTI was founded in 1983, and literally pioneered the development of mobile superconductive magnetic resonance imaging (MRI) services. We have emerged as the largest provider of medical shared services in the U.S., operating in over 40 states. MTI provides a variety of shared services -- mobile diagnostic imaging and treatment technologies with trained clinical and technical personnel. Our mobile units include MRI, computed tomography (CT), lithotripsy, and mammography. One of the reasons I founded MTI was to offer hospitals and physicians the means to acquire advanced technology without investing in costly diagnostic equipment.

We, as a provider of medical services and as a consumer with over 700 employees participating in a cafeteria health care benefit plan, are very interested in the current health care reform debate. With health care expenditures for 1990 alone totaling $666.2 billion -- and projections of $1.1 trillion (in 1990 dollars) for the year 2000 -- I feel very strongly both as a provider and consumer that something has to be done to control this ever spiraling phenomena.

We have seen, on a first hand basis, the rapid advances in medical technology contributing to a "medical arms race". Hospitals compete with one another to have the newest and best in technology available in order to attract patients and to keep doctors from shifting to rival hospitals. An example of this was reported to Congress last year by the General Accounting Office (GAO). GAO cited a case where three MRIs were utilized in the county of Altoona, Pennsylvania, despite the availability of a MRI in the next county.

GAO concluded:

> With these machines, physicians apparently performed more MRI scans per resident than were done in Philadelphia and many other hospitals in the state. Although hospitals purchase capital equipment, it is the physicians who bill Medicare and other payers for the services they provide using that equipment. Unnecessary capital acquisition drives up overall health spending and all payers -- business, government and private insurers -- foot the bill.

The proliferation of technology and services is an important factor in the rising cost of health care. According to Diagnostic Imaging's 1990 Report, total annual MRI costs alone in 1989 approached $3 billion. Advanced diagnostic equipment and radiation therapy equipment can contribute from 10 to 50 percent to overall U.S. health care spending, depending on the survey source.

However, new technologies, such as the MRI, have enabled physicians to diagnose and treat patients more effectively. For example, today, more than 37 million Americans of all ages suffer from arthritis. According to Joel Silverfield, a Tampa rheumatologist in a recent Arthritis Today, "...the MRI has largely replaced the CAT scan in arthritis diagnosis." Dr. Silverfield notes that, "the MRI often shows exactly what the problem is in a joint, helping us to distinguish arthritis from other problems such as torn cartilage or avascular necrosis..." Moreover once arthritis has been diagnosed, doctors track the progression of the disease and monitor the effectiveness of treatment by analyzing changes in tissue through MRI.

Arthritis is only one area that MRIs are being utilized because of their effectiveness in diagnosing patients. Cardiologists are awaiting the development and approval of an echo-planar MRI, a technology that will allow doctors to measure the flow of blood in a patient which will help to prevent heart attacks and identify blood clots.

New technologies such as MRI offer tremendous potential to improve the quality of health care. Access to these technologies is vital, but the cost of access must be controlled. If an incentive for shared systems is built into the Medicare reimbursement system, you would see a marked decrease in the growth of health care costs. More hospitals would use shared services thereby reducing the actual costs of maintaining and operating highly advanced -- and expensive technology.

Current transition rules accompanying the Medicare reimbursement system for inpatient hospital care only address the sharing of equipment among providers. What is needed to stem the proliferation of duplicate equipment and technology is an incentive built into the reimbursement system for shared services provided through service agreements with shared service companies.

For those hospitals who have been providing MRI services through contracts with shared services vendors, such incentives would reduce the purchases of new MRI systems, reducing unnecessary investment in new technology and encouraging more effective resource utilization.

How would shared services cut costs?

1. Shared services provide cost-effective access to the newest diagnostic and treatment technologies. Fixed MRI units work, on average, five days a week. Whereas, those used through a shared services network are utilized an extra day a week - - or to translate, there is 20 percent more utilization of assets, and an overall cost savings. In addition, without incentives to share, many hospitals will acquire MRIs that would be fully utilized under three days each week. Once again, this proliferation of equipment will further increase health costs unnecessarily.

Average operating costs for MRI systems including depreciation and staffing is $1.3 million annually. If you assume a MRI unit is being used five times a day, five days a week, 50 weeks a year, you are processing 1,250 cases a year and the costs per case would equal $1,040. Now if you process 20 cases a day 6 days a week, 50 times a year, you process 6,000 cases a year and

the cost per case would equal $216. Thus one key to reducing the economic impact of new technology is to have high utilization of assets.

2. Increased use of shared services will provide the benefits of these new technologies while stemming the increase in health care costs associated with the purchase and operation of expensive diagnostic technologies such as MRI. Last month the Advisory Council on Social Security released its findings on our health care system. The Council cited "technology explosion" as one of the "internal forces that contain perverse incentives that increase health care spending."

The Council further noted:

> The range of beneficial diagnostic and therapeutic interventions has been expanding rapidly for several decades...
>
> A new medical technology does not usually reduce spending because, in addition to the capital cost involved, it also generates new costs for operation and maintenance. Diagnostic therapies such as MRI, for example, require not only the facility in which images are made, but also technicians trained in the proper use of the equipment and physicians who understand the new "output". The costs of operating new equipment often exceed the amortized cost of the equipment itself...

With shared services arrangements hospitals, clinics and group practices not only gain access to the newest diagnostic and treatment modalities but also eliminate having to make a long-term commitment of capital for equipment purchase, repair and maintenance, facility space, staff and training.

Let me share with you just two examples that are illustrative of the benefits of shared services:

> Through a shared network, hospitals in Milwaukee, Wisconsin have gained cost-effective access to mobile MR and CT units that provide the latest technology which individually would have been cost prohibitive.
>
> A hospital in Valdosta, Georgia, shows why it makes economic sense to use shared services for lithotripsy. The volume of kidney stone candidates did not justify the purchase by the hospital of a $1,500,000 piece of equipment that would be utilized 25 times a year. Because South Georgia Medical Center is part of a lithotripsy network with six other institutions it has access to this new technology at a greatly reduced cost factor. The lithotripter visits the Valdosta facility every third Friday and treats an average of 1 to 4 patients.

3. Without shared services, the cost of acquiring and operating new technologies by hospitals is extremely high, driving up health care costs. Despite the appropriateness of shared services as part of the solution to runaway health costs, the temptation to purchase dedicated technology, even if it will be underutilized, remains strong. Decades of routine spending for

new equipment and programs have entrenched an attitude among many hospitals and physicians that they must have their own facility regardless of whether it is used efficiently. This tendency is imbedding tremendous costs within the health care system as new technology is being purchased. More efficient sharing of resources could save the medicare programs nearly $500 million in payments for MRI services alone.

The Advisory Council further reported:

> The proliferation of technology and services is an important contributor to higher spending. Hospitals add duplicate programs, equipment and technology to attract physicians and patients. According to one report, hospital spending on equipment increased an average of 16 percent in 1990 and is projected to rise another 10 percent in 1991.
>
> New technologies are often viewed as a profit source without evaluating the community need for them. Diagnostic imaging systems and laboratory capacity have sometimes been purchased primarily with an eye to generating revenues. When utilization review, payment systems, and market competition fail to discourage unnecessary use of such technology and services, the result is excess costs.
>
> Physician ownership of diagnostic facilities also contributes to more spending. A study by the Inspector General of the Department of Health and Human Services found that physicians who own or invest in laboratories order 45 percent more tests than those who do not.

4. The use of shared services can also ensure that experienced clinical and technical staff are available for these new programs. Many hospitals, and especially rural facilities, have difficulty recruiting and retaining highly trained personnel. Shared services provide experienced clinical and technical staff, as well as training programs for hospital staff.

It is also important to note that shared services not only allows for a tremendous savings, but, it does so at no sacrifice to quality. I have been asked on numerous occasions whether the quality of shared services is equal to that of dedicated services. In polls of both physicians and patients, the use of shared services for MRI more than satisfies physician concerns about availability. With equipment, such as MRI, designed specifically for shared use, the technological capability and performance is identical to a dedicated facility. In short, there is no reason to sacrifice quality in order to control costs in this instance.

Shared services would certainly meet two of the goals of Congress -- contain costs and provide wider access to high quality health care. Without attention on our part, traditional forces will make it difficult for shared services to emerge as an important part of the solution to our growing health care problem. Let me reemphasize how important it is that incentives are built into the reimbursement system for shared services provided through service agreements with shared service companies. By creating an impetus in the medicare reimbursement system to utilize a shared services system, hospitals and physicians will be motivated to reduce health care costs.

STATEMENT OF THE NATIONAL ALLIANCE FOR THE MENTALLY ILL

Mr. Chairman, the National Alliance for the Mentally Ill (NAMI), a 140,000 member grassroots advocacy organization comprised of family members of persons with severe mental illnesses, as well as those persons themselves, appreciates your invitation to comment for the hearing record on health insurance reform. As you know, at least 3.5 million Americans are afflicted with a mental illness that can be categorized as severe and persistent, yet only 20% of those actively seek treatment services. While stigma is a major factor, lack of access to desperately-needed services has always been a major deterrent.

Members of the Republican Task Force testified before your Committee on June 18, 1992 in favor of health insurance reform that relies on voluntary tax incentives to increase access to care for the nation's 35–40 million uninsured citizens. Certainly tax incentives to purchase insurance coverage is a reasonable element to comprehensive reform, but it is only part of a national solution. On the other hand, this approach embodies a proposal that we find most disturbing—the override of state minimum benefit mandate laws, which in the case of mental illness or mental health mandates, are presently in effect in over 30 states. For many millions of Americans these state legislative efforts guarantee at least a minimal level of insurance coverage against the costs of treatment. While our members have been active at the state level in working for these mandate laws, the National Alliance for the Mentally Ill is, at the present, in the forefront of more comprehensive efforts to remedy this nation's legacy of callous discrimination against persons afflicted with a treatable biologically-based mental illness. Our 140,000 members all share a common experience with their insurance coverage—inadequate protection against financial catastrophe when a family member is unexpectedly diagnosed with and must seek treatment for an episode of schizophrenia or severe depressive illness. Persons with a severe mental illness *routinely* face arbitrary day and dollar limits on mental illness treatment services; extraordinary cost-sharing unlike that for any other physical illness; and discriminatory lifetime benefit limits on covered services. Personal bankruptcy or loss of one's home or other assets is typically the cruel result of unreimbursed bills for intermittent hospital stays and prescription medications. With resources depleted, the person with a severe, but treatable, mental illness must then rely on services from the under-funded, under-staffed public mental health system where admission criteria are rigid and budget cuts are closing entire hospitals. It is not difficult, Mr. Chairman, to predict the next "treatment setting" for these persons—the streets of our towns and cities and the local jails. We call to your attention the just-released HHS/HUD Report, "Outcasts on Main Street" for a shocking glimpse at the scope of this problem, part of which results from substandard insurance protection.

Mr. Chairman, NAMI holds these tax-incentive-based proposals to the same standards against which all of the other current reform proposals are evaluated. We have articulated these on a number of occasions beginning in August of last year when our national Board of Directors opted not to endorse the Senate Democratic "Pay or Play" proposal. The standards we seek in comprehensive reform efforts include:

I. Access to affordable third-party health insurance coverage for all Americans at affordable levels of out-of pocket expenses.

II. Coverage of disorders of the brain equal in scope and duration to coverage of all physical disorders.

III. By consequence, elimination of any arbitrary lifetime limitations on benefits payable for the treatment of mental illness.

IV. Coverage of all proven-effective modes of treatment—inpatient, outpatient, pharmacologic, case management, rehabilitative, and others appropriate to the individual's needs.

V. For persons dependent on the public sector (Medicare and Medicaid) coverage of mental illness benefit *at least as comprehensive* as presently available.

Regrettably, all of the small group market reform and tax-incentive-based proposals fail to meet any of our standards, because they do little to assist persons with mental illness, as well as all persons with disabilities. For example, the proposed deductions will not be adequate to cover the cost of insurance today, let alone the more comprehensive coverage we seek. Persons with mental illnesses and their families will still incur large out-of-pocket expenses, since the value of the deduction will presumably be applied to the purchase of a yet-to-be-developed state-defined "bare bones" insurance package, which will certainly not adequately cover treatment costs associated with severe mental illnesses. H.R. 5325, the "Action Now Health Care Reform Act of 1992," introduced by the House Republican Leadership, seeks

to implement reforms through the states with standards based on model laws and regulations developed by the National Association of Insurance Commissioners (NAIC). States will define "basic" and "standard" insurance policies which will most likely regard mental illness treatment services as "optional" benefits.

Further, moving a step backward instead of forward, **state-mandated benefits would be repealed,** and states instead would be required to negotiate a "bare bones" health care package with the insurance industry for an individual state-defined package of benefits. Today, some 30 states, including the District of Columbia, require that minimum mental health benefits be either provided *or* offered. Of those 30 states, *17 states* (Colorado, Connecticut, the District of Columbia, Hawaii, Kansas, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New York, North Dakota, Ohio, Oregon, Virginia, and Wisconsin) *require coverage* of inpatient and/or outpatient treatment of mental illness. The remaining *13 states* (Arkansas, California, Florida, Georgia, Illinois, Kentucky, Louisiana, Missouri, Mississippi, Tennessee, Vermont, Washington, and West Virginia) *require that insurance companies* make available or offer certain *benefits* for mental health care. But under small market reform proposals **no state would be required to cover treatment for mental illness.** History has taught us that without state or federal statutory protections, the insurance industry will not offer this coverage voluntarily.

If state mandates, which currently require that a certain level of mental health coverage be offered, are eliminated, then persons suffering from mental illnesses may be able to get general medical insurance, but *not necessarily any mental illness coverage.* The preemption of state benefit mandates, which supposedly promote administrative savings, will be counterproductive if each state is responsible for defining its own "basic" and "standard" benefit packages *without* a Federal minimum standard that includes adequate mental health coverage. *Persons with mental illnesses could find themselves worse off than they are now!*

If a new federal law is going to preempt state minimum benefit laws, then it must replace them with a specific federal minimum benefit. This benefit should be comprehensive, and equivalent in scope and duration to coverage for other severe illnesses. The approach outlined in H.R. 5325 would not make the system of benefit design more uniform, but rather move in the opposite direction. A federal benefit standard facilitates the provision of health care to all Americans, not just those who might have the good fortune to reside in a so-called "high effort" state. If a specific federal benefit is to be set, it should replicate the comprehensive coverage outlined in the new bill introduced by Senator Pete Domenici, "The Equitable Health Insurance Coverage of Severe Mental Illnesses Act of 1992." Six Senators have co-sponsored this bill as of today.

This bill is the only proposal currently before Congress which adequately redresses the mental illness benefit inequities which are now institutionally rooted in the American health insurance industry. S. 2696 defines equitable, non-discriminatory coverage of mental illnesses as health insurance that would **"cover services that are essential to the effective treatment of severe mental illnesses in a manner that is not more restrictive than coverage provided for other major physical illnesses, that provides adequate financial protection to the person requiring the medical treatment for a severe mental illness, and that is consistent with effective and common methods of controlling health care costs for other major physical illnesses."**

Senator Domenici's legislation provides: stop-loss protection for catastrophic expenses; coverage of unlimited facility based care, with cost control using precertification review, a mixed prospective and cost-based payment method, and a deductible equal to one day's cost at the facility; coverage of unlimited outpatient medical management with coinsurance and provider reimbursement set on a par with other medical procedures to encourage use of cost-effective ambulatory treatment; coverage of visits for psychotherapy, with coinsurance and fees set to ensure effective cost control of high-demand services; and coverage of prescription drugs essential to the cost-effective treatment of severe mental illnesses.

The "Equitable Health Insurance Coverage of Severe Mental Illness Act" (S. 2696) outlines a model benefit package that could easily be inserted into any of the broader insurance reform plans (i.e., "pay-or-play," "single-payer," "small-market reform," etc.). If enacted, this bill will actually decrease this nation's investment in mental health care costs as persons will now be entitled to reasonable levels of cost-effective treatment and will therefore not be dependent upon the public sector.

Mr. Chairman, we thank you for allowing NAMI to comment on the shortcomings associated with tax-incentive reform efforts. We ask you to join with us, Mr. Chairman, and help craft a comprehensive federal response to a long-overdue blight in our health care system. Thank you.

STATEMENT OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

The National Association of Social Workers (NASW) represents 140,000 professional social workers nationwide, two-thirds of whom practice in health and mental health care settings. The association is pleased to submit this written testimony for the record of the Finance Committee Hearingon Universal Coverage through Public Health Insurance Programs.

NASW has a longstanding history of advocating for a national health care program that can provide comprehensive health, mental health, and long-term care services to all Americans. Our association has invested considerable energy in the current debate on health care reform, and in 1990 the Board of Directors approved the NASW National Health Care Proposal. On June 9, 1992, this proposal was introduced by Senator Inouye as S. 2817, the National Health Care Act of 1992. S. 2817 would replace the more than 1500 public and private health insurance programs that currently exist with a single-payer, publicly-administered system.

S. 2817 provides coverage for comprehensive health, mental health, and long-term care benefits. In addition to traditional hospital and outpatient primary care, the bill includes: disease prevention and health promotion services; care coordination services; mental health care that is covered in the same fashion as physical health care; substance abuse services; rehabilitation services; long-term care, including home and community-based services; hospice care; prescription drugs and dental and vision care. The bill also includes service delivery improvements, such as the use of integrated health services to enhance continuity of care and service efficiency, care coordination for individuals with chronic or multiple health problems, improved planning for health and mental health service delivery for inner city and rural populations, and screening and care coordination systems for the delivery of long-term care.

NASW believes that the single-payer approach provides the best response to our nation's health care crisis. A single-payer system offers the means to ensure that every American has access to high quality health, mental health, and long-term care services. And we believe that such a financing and payment system is one that the United States can afford—both now and in the future.

A single-payer system is the only reform proposed thus far that adequately addresses the problems of both access and cost. Everyone would be covered under the same plan, eliminating the many tiers of private and public health care coverage that are available today. Cost containment and administrative cost savings are key elements of the single-payer approach with the opportunity to control costs through global budgeting, negotiated payment rates to providers, and efficient distribution of health care resources and technology. In fact, the U.S. General Accounting Office (GAO) reported that the U.S. could achieve savings of $67 billion in the short-run by shifting to a Canadian style, single-payer system. Both GAO and the Congressional Budget Office have stated that a single-payer system could save enough funds to allow universal coverage without consumer cost-sharing.

The most commonly expressed concern that is directed toward the single-payer approach in Washington, D.C. is: "It's not politically feasible." While not underestimating the weight of this concern, it's important to note that it is a remark that is usually expressed inside the Capitol Beltway. It is also a statement that more aptly reflects concerns for certain segments of the health care industry rather than the merits of a single-payer approach to the population as a whole.

In assessing political feasibility, it is important to look at the benefits that the following interest groups could achieve through a single-payer health insurance system:

BENEFITS FOR HEALTH CARE PROVIDERS

- Elimination of much of the administrative overhead and paperwork that currently consumes a large portion of health care providers' time, such as billing, collecting, and reviewing payments for 1500 insurance programs, each with their own rules and requirements for obtaining payment.
- Greater professional autonomy—clinical freedom—for health care providers to deliver care without the interference of outside parties whose primary interest is to contain costs.
- Guaranteed payment to providers, thus eliminating the need to recover costs for uncompensated care through cost shifting, as well as the fear of closure or curtailment of services due to uncompensated services.

BUSINESSES

- Elimination of domestic and international competitive disadvantages for companies providing health coverage for their employees.
- Confidence in hiring new employees without worrying that hiring an older person or someone with a preexisting condition will raise insurance costs.
- Fair distribution of health care costs among all businesses, limiting the disproportionate financial burden that now exists among those firms that provide good benefits.
- Controlling runaway medical inflation and eliminating waste would limit businesses' investment in health care and allow them to improve their operations and expand job opportunities.

BENEFITS FOR CONSUMERS

- Universal coverage for comprehensive care regardless of income or pre-existing conditions.
- A "user-friendly" system of obtaining care—a single-payer system is simple to use and simple to understand.
- Flexibility for workers to move from one employment to another without fear of losing health insurance benefits.
- Consumer freedom to select their own providers.

BENEFITS FOR SENIOR CITIZEN CONSUMERS

- Coverage of prescription drugs and long-term care services, two of the highest costs that seniors face today.
- Elimination of out-of-pocket costs and balance billing for covered services, Medicare deductibles and cost-sharing, and the need for Medigap insurance.
- Protection for retirees who face cutbacks in coverage and/or increased cost-sharing as businesses reduce retiree benefits.
- Protection for retirees from losing health care benefits if their firm goes bankrupt.

Everyone is vulnerable through our current system of health insurance coverage. The polls reflect that feeling of vulnerability.

- A 1989 survey by the Census Bureau found that *in a 28-month period more than one American in four (28%) reported they were without health insurance coverage for some period of time.* A recent New York Times/CBS poll similarly found that 29% of the public lacked health insurance at least temporarily during the past year.
- A 1990 *Los Angeles Times* survey found that one in six adults (18%) under age 65 reported their health benefits were reduced over the previous two-year period. The same poll also showed that Americans pay an average of 26% of their health care bills out-of-pocket, and one in six (19%) report paying more than 40% of these costs directly.
- A 1991 *New York Times*/CBS poll showed that one in ten Americans have at least some time stayed in a job they wanted to leave mainly because they did not want to lose health coverage. This phenomenon, known as "job lock," is most common among middle-income households.

Other polls also reflect the growing sentiment among the U.S. population for change in the health care system.

- A 1988 poll conducted by Louis Harris and Associates and the Harvard School of Public Health, showed that *89% of Americans believe that the U.S. health care system requires fundamental chance or complete rebuilding.*
- In two surveys conducted in ten nations, it was found that *Canadians were the most satisfied with their current health care system and Americans the least.* The countries surveyed were the United States, England, Canada, Netherlands, Italy, West Germany, France, Sweden, Australia, and Japan.
- *A 1990 Los Angeles Times poll showed that 66% of Americans would prefer the Canadian health care system over the American system.* This poll replicated a 1988 poll conducted by Louis Harris and Associates, which found that 61% of Americans expressed a preference for the Canadian system. Both polls showed that the desire for the Canadian system was strongest among middle-income Americans.
- An NBC survey conducted in 1989 found that *67% of the American public favored "a comprehensive national health plan that would cover all Americans and be paid for by federal tax revenue."*

Two years ago very few individuals or groups supported a single-payer national health program. Today, single-payer plans have been introduced in 20 states around the country and have received significant support.

HOW DO WE PAY FOR A SINGLE-PAYER SYSTEM?

A single-payer system does not require massive dollars from new sources of revenue. What it does require, however, is a transfer in how we collect and pay for health care through the tax system. We believe we need to shift the dollars currently spent on health care—a combination of premiums, copayments, deductibles, and out-of-pocket costs now paid by American families and businesses, along with current federal and state contributions—to a more efficient and equitable system of payment.

DOES A SINGLE-PAYER SYSTEM PRESUME RATIONING OF CARE?

We all know that rationing occurs now. When 37 million people are uninsured, when only 41% of those below the poverty line receive Medicaid benefits, or when 1/5 of all pregnant women do not receive prenatal care, as was the case in the 1980's, there is rationing. Our two-tier health system provides inferior, limited, or no care to those who are poor, without insurance, or underinsured.

We know from data published by health analysts, the General Accounting Office, and the Office of Technology Assessment that tens of billions of dollars are currently spent on unnecessary procedures and inefficient use of health resources—dollars that can be used for needed care. We also know that there is inefficient use of hospitals. The average occupancy rate of hospitals is 65%. This means we pay an astronomical amount of fixed costs to keep these hospitals in business. Clearly, we need to consolidate some acute care hospitals, convert others into specialty hospitals, and turn others into other needed facilities, such as rehabilitation centers or community outpatient centers. Again, this will save money and allow for better, cost-efficient care for everyone.

More equitable distribution and efficient use of health care resources, the establishment of practice guidelines, better consumer education, and expanded review of the quality and cost of care will enable this system to meet the health needs of most Americans. While some rationing may occur, we believe that it will be far less than we have now. We also believe that people will be willing to accept some limitations if they have access to good, quality health care when they need it.

In addition to our views on the advantages of the single-payer approach to national health care reform, the association would like to submit a few comments regarding two other categories of reform legislation being considered by this Committee—the small group market health insurance reform approach and the employer "play or pay" approach.

SMALL GROUP MARKET HEALTH INSURANCE REFORM

The small group market reform approach proposes to increase access to health care through the purchase of private health insurance. Most of these bills propose to eliminate state mandates that require insurance policies to cover specific types of services or service providers. In addition, many of these proposals would overturn state laws that protect consumers through regulating the use of managed care and utilization review. The theory behind the insurance reform proposals is that small employers will purchase insurance coverage for their employees it if is made more affordable by limiting benefits and limiting regulation of managed care.

The more positive aspects of some insurance reform proposals include provisions that attempt to regulate private insurance coverage for small groups. These include: a prohibition on denying coverage to groups on the basis of health status or other criteria; limits on premium increases; limits on the use of pre-existing condition exclusions; and policy renewal requirements.

Disadvantages of the small group market insurance reform approach include:

- Small group market insurance reform does not address the underlying problems of rising health care costs and declining access. Because it focuses attention on the small group market, the problems of individuals seeking insurance, people in larger groups, and employers who self-insure remain unaddressed.
- Small group market health insurance reform can not make coverage sufficiently affordable to significantly expand coverage. According to the Robert Wood Johnson Foundation, which has funded small group reform efforts, at best only 20% of those small firms not now providing insurance would do so under these proposals.

- Even if persons with pre-existing conditions can obtain coverage, the scaled-back benefit packages fail to provide many of the services they need including mental health, prescription drugs, rehabilitative services, and home care.
- Use of the private insurance model to expand access is too costly. Private insurers, who spend 33.5 cents to provide a dollar's worth of health care, can not compete with a government-run insurance system such as Medicare, which spends only 2.5 cents per health care dollar for administration.
- None of the insurance reform proposals address claims denials—profit-minded insurers will still have an incentive to deny claims.

NASW is particularly concerned with the "bare bones" coverage that is offered through many small group market health insurance reform proposals. They are no bargain, and we think it is poor public policy to suggest that insurance coverage can be made more affordable by eliminating critical benefits and consumer protections, and by shifting costs to the beneficiary.

EMPLOYER "PLAY OR PAY" APPROACH

The employer "play or pay" approach also represents an incremental approach to health care reform and attempts to increase access to health care coverage to as many Americans as possible through employer-based, private health insurance and an expanded public program. It provides employers a choice—either provide the basic benefit package to employees ("play") or "pay" the government to insure their employees. Universal coverage is achieved through an expanded public plan that would cover current Medicaid beneficiaries, the unemployed, and workers whose employers opted to "pay." Most "play or pay" proposals also include insurance reform provisions.

The greatest criticisms aimed at the employer mandate approach are the difficulty in containing costs and inability to generate cost savings. In fact, many critics suggest that the approach creates a system in which employers will opt to "play" for younger healthier workforces and "pay" for higher risk workforces, leaving the federal government with the job of providing coverage for segments of the population for whom it is most costly to insure. In addition, businesses which opt to "play" are faced with an open-ended financial responsibility for a defined benefit level, which, because of inadequate savings, can increase dramatically over time.

We believe that the quality of health and mental health care that is available in the United States is superior to that offered in most nations. Unfortunately, Americans are spending increasingly more for health care and receiving less than citizens of most other countries in the industrialized world. On October 2 the Department of Health and Human Services reported that the nation's health spending reached a record $666.2 billion in 1990. According to the Democratic Study Group's special report on health care in May, health care in the U.S. is the most expensive in the world. The DSG special report indicates that the cost of U.S. health care is not due to a greater use of health services in the U.S. than in other countries, nor does it result in higher rankings on the basic indicators of health status as compared to other industrialized nations.

Our association's policies support the provision of health care as a basic right, not a commodity. Accordingly, we believe that the goal of health care reform ought to be the assurance that quality health, mental health, and long-term care services are available to all Americans. NASW is convinced that a single-payer national health care program is the means to accomplish this goal. Accordingly, we are pleased to support both S. 2817, the National Health Care Act of 1992, and S. 2320, the Universal Health Care Act, which have been referred to this Committee.

STATEMENT OF THE NATIONAL CENTER FOR POLICY ANALYSIS

INTRODUCTION: WHY HEALTH CARE COSTS KEEP RISING [1]

The reason why health care costs keep rising is clear. When we enter the medical marketplace, most of the time we are spending someone else's money rather than our own. If we paid for food, clothing, housing and life's other necessities the way we pay for health care, the cost of those items also would soar.

Under most employer-provided health insurance plans, employees effectively have a company credit card allowing them to spend freely in the hospital equivalent of a shopping mall. There are plenty of experts ready to help shoppers learn what is available. The shoppers enjoy the benefits of the spending spree, and employers get the bill.

It would be a mistake to believe that employers ultimately pay this bill, however. Health insurance is a fringe benefit which substitutes for wages in the total employee compensation package. The more costly health insurance becomes, the smaller the remaining funds available for wage and salary increases. The ultimate victims of waste in the medical marketplace are employees. This is one reason why take-home pay has been relatively stagnant over the past two decades, even though total compensation has been rising.

THIRD-PARTY HEALTH INSURANCE

Many people believe that health care spending should be determined by medical "needs." Yet if we followed the practice of spending health care dollars whenever a need was being met (or a medical benefit created), we could easily spend our entire gross national product (GNP) on health care. In fact, we could probably spend half of the entire GNP on diagnostic tests alone.

The Potential Demand for Health Care. What prevents medical costs from being even higher is that patients are constrained by obstacles such as time, money and inconvenience. For example, medical science has identified 900 tests that can be done on blood.[2] Except for the cost and inconvenience, why not make all 900 part of our annual checkup? Similarly, an annual checkup could include a brain scan, a full body scan and numerous other tests all of which are valuable even to people who appear healthy.

As an example of how the demand for the services of primary care physicians could soar, consider:[3]

- In any given year, Americans make about 472 million office visits to primary-care physicians.
- If only 2 percent of nonprescription drug consumers sought professional care rather than self-medicating, the number of patient visits would climb to 721 million.
- The number of primary-care physicians would need to increase by 50 percent to meet the increased demand.
- If every person who now uses nonprescription drugs chose professional care over self-medication, we would need 25 times the current number of primary-care physicians.

How Third-Party Insurance Increases the Demand for Health Care. The vehicle by which we spend other people's money in the medical marketplace is third-party health insurance (provided by an employer, an insurance company or government). Prior to 1965, increases in health care costs were relatively modest because a large part of the payment was made out-of-pocket by patients. Since then, Medicare and Medicaid have expanded government third-party insurance to more and more services for the elderly and the poor, and private health insurance has expanded for the working population.

- About 95 percent of the money Americans now spend in hospitals is someone else's money at the time they spend it.
- Four-fifths of all physicians' payments are now made with other people's money, as are three-quarters of all medical payments for all purposes.

When patients pay only a fraction of the real cost of the health care they receive, they have an incentive to over-consume. Since we pay only 23 cents out-of-pocket for every dollar of medical care we receive, we have an incentive to continue consuming until medical care is worth only 23 cents on the dollar to us.

The expansion of third-party insurance coverage since 1965 has had a predictable consequence: health care spending has soared from 6 percent to 12 percent of GNP, and the rate of increase shows no sign of abating.

Numerous studies have shown that the amount of medical care people consume varies with the out-of-pocket price they have to pay—often with no effect on health. For example:[4]

- A Rand Corporation study found that people who had access to free care spent about 50 percent more than those who had to pay 95 percent of the bills out-of-pocket (up to a maximum of $1,000).
- People who had free care were about 25 percent more likely to see a physician and 33 percent more likely to enter a hospital.
- Despite these differences in consumption, there were no apparent differences between the two groups in health outcomes.[5]

The Rand study was conducted from 1974 to 1982. A $1,000 deductible over that period would be equivalent to a deductible between $1,380 and $2,482 today.

Third-Party Payment of Small Medical Bills. Using insurers to pay small medical bills is especially wasteful. It is comparable to using an insurance company to pay monthly utility bills. That might be convenient, but the convenience would be costly.

- Studies show that physicians spend an average of $8 for each insurance claim they submit.
- Most employers and insurance companies spend another $8 for every check they write.
- If the third-party payer investigates the legitimacy of a claim, a $25 physician's fee can easily generate another $25 in administrative costs thus doubling the cost of medical care.

Considering that a substantial portion of insurance claims are for small-dollar expenses, using third parties to pay small medical bills adds substantially to the nation's annual health care costs.

THE SELF-INSURANCE ALTERNATIVE

People familiar with insurance have always known that it creates perverse incentives for the insured. In order to take advantage of the benefits under a policy, the beneficiaries do things they would not otherwise do.

In recognition of this fact, insurance in most fields is restricted to risks beyond the control of the insured. (For example, automobile casualty insurance does not pay for oil changes, tire rotations, break adjustments and other routine maintenance even though these activities are important for the health of a car and the safety of the driver.) Financial advisers almost always recommend high-deductible policies because small-dollar claims are the ones where the most abuse is likely to occur, and the premiums needed to cover these claims are often much too high relative to the extra coverage. The same principles apply to health insurance.

The alternative to third-party insurance is self-insurance. Rather than relying on insurers to pay every medical bill, we could put money aside in personal savings for the small expenses and use insurance only for rare, high-dollar medical episodes. As we shall see, such a practice would result in much lower premiums and curtail a great deal of wasteful spending.

Yet instead of exploiting opportunities for self-insurance and taking advantage of its benefits, in health care we have moved in the opposite direction with insurers paying for all manner of routine expenses, including checkups and diagnostic tests, even when there is no illness and no risky event has occurred. Why have we failed to apply the lessons learned in other insurance fields to health insurance? The most Important reason is the tax law.

HOW THE TAX LAW ENCOURAGES THIRD-PARTY INSURANCE AND PENALIZES INDIVIDUAL SELF-INSURANCE

One strange feature of the tax code is that a physician's fee paid by an employer (or an employer's insurance carrier) is paid with pretax dollars, whereas fees paid out-of-pocket by employees must be paid with after tax dollars. As a result, the tax law encourages (subsidizes) 100 percent health insurance coverage (with no deductibles and no copayments) for all medical expenses.

Federal tax law has an enormous impact on employee benefit plans because individual marginal tax rates are so high. Even a moderate wage earner in the U.S. economy gets to keep less than 70 cents out of each *additional* dollar earned.

- For an employee facing an income tax rate of 15 percent and a combined (employer plus employee) Social Security tax rate of 15.3 percent, federal taxes take 30.3 cents out of each additional dollar of wages.
- If the employee faces a 6 percent state and local income tax, the marginal tax rate is 36.3 percent, leaving the employee with less than two-thirds of a dollar of wages in the form of take-home pay. The results are even worse for employees in higher tax brackets:
- Workers in the 28 percent federal income tax bracket face a marginal tax rate of 43.3 percent leaving them with less than 57 cents in take-home pay out of each additional dollar of earnings.
- If state and local income taxes apply, these workers take home only 51 cents of each additional dollar of earnings.

Because wages are taxed and health insurance benefits are not, health insurance is more valuable to employees than additional wages.[6]

- For an employee in the 15 percent tax bracket (and facing a 15.3 percent FICA tax), federal tax law makes $1.44 of health insurance benefits equivalent to a

dollar of take-home pay because $1.44 in gross wages will be reduced by 44 cents in taxes.

- For an employee who is in the 28 percent bracket, $1.76 of health insurance benefits is equivalent to a dollar of take-home pay.
- For a higher-paid employee also facing a 6 percent state and local income tax rate, $1.97 of health insurance benefits is equivalent to a dollar of take-home pay.

A great deal of waste can be present in the purchase of health insurance and still allow health insurance to be preferable to wages. For example, if an employer attempted to give the higher-paid employee $1.97 in wages, the employee's take-home pay would be only $1.00 after taxes are paid. As a result:

- For a highly paid employee, $1.97 spent on health insurance need only be worth $1.01 to be preferable to $1.97 of gross wages.
- Thus, 96 cents of $1.97 (or 49 percent of the premium) can represent pure waste and still leave health insurance preferable to wages for the employee.

This is why employees tend to prefer generous (and wasteful) health insurance coverage—coverage that they would not buy out-of-pocket without tax subsidies. Note also that the higher the tax bracket, the greater the economic incentive to purchase more health insurance. Higher-paid workers tend to dictate the contents of employee benefit plans and impose their choices on all other workers. Moreover, many current employee benefit plans were shaped decades ago, when marginal tax rates were much higher and the incentives for waste even greater.

The total tax deduction for employer-provided health insurance is about $60 billion per year roughly $600 for every American family. Although this system may appear to benefit large companies with more generous employee benefits, in many cases these companies are trapped by benefit plans that are eating into company profits, raising production costs and keeping wages lower than they otherwise would be. The current system not only encourages and subsidizes rising health care costs, it also harms the very industries and companies which are subsidized the most.

WHY LOW-DEDUCTIBLE HEALTH INSURANCE IS WASTEFUL

Because employees (through their employers) are able to purchase health insurance with pretax dollars, but individuals are not allowed to self-insure (personal savings) for small medical expenses with pretax dollars, people often buy low-deductible health insurance and use insurers to pay for small medical bills that would be much less expensive if paid out-of-pocket.

The Cost of a Low-Deductible Policy in Cities With Average Health Care Costs. The cost of catastrophic health insurance is usually quite low. Consider a standard individual health insurance policy for a middle-aged male in a city with average health care costs, such as Indianapolis. If the policy has a $2,500 deductible, the policyholder is at risk for $2,500. The insurance company, on the other hand, is at risk for $1 million. Given an average premium, this health insurance costs the policyholder about 6/100th of one penny in premiums for each dollar of coverage.

Now contrast this policy with a $1,000-deductible policy which has a 20 percent copayment for the next $5,000 of expenses. In theory, the $1,000 deductible gives the policyholder $1,500 of extra insurance coverage. But because of the 20 percent copayment, the additional coverage actually is only $1,200.[7] People who choose the $1,000 deductible will pay about $255 in additional premiums in return for $1,200 of additional insurance coverage. As a result each additional dollar of insurance coverage costs the policyholder 14 cents.[8]

- Lowering the deductible from $1,000 to $500 costs 64 cents in additional premiums for each additional dollar of insurance coverage.
- Lowering the deductible from $500 to $250 costs 77 cents in additional premiums for each additional dollar of insurance coverage.

In general, buying a $250-deductible policy rather than a $500 deductible is a good deal provided that the policyholder is confident he will have at least $500 in medical expenses. Even in that case, the gain is a small one—a dollar's worth of medical expenses for each 77 cents in premiums. For the vast majority of people, however, a low-deductible policy is quite wasteful. Considering the administrative expenses, insurers on the average will pay out only 54 cents in claims for each 77 cents in premiums. Policyholders as a group, therefore, will pay far more in premiums than they will receive in benefits.

The Cost of a Low-Deductible Policy in Cities with High Health Care costs. In general, the higher the health care costs in an area, the more expensive low-deductible health insurance becomes. In the city of Miami:

- Lowering the deductible from $2,500 to $1,000 is quite expensive 33 cents for each additional dollar of coverage.
- Lowering the deductible from $1,000 to $500 is inherently wasteful costing $1.79 for each additional $1.00 of coverage.
- Lowering the deductible $500 to $250 costs $2.20 for each additional $1.00 of coverage $1.20 more than any possible benefits the policyholder could derive.

OPPORTUNITIES FOR PREMIUM SAVINGS IN LARGE GROUPS

Considerable savings are possible for individuals and families who choose higher deductible policies for two reasons. First, when policyholders spend more of their own money on small medical bills, they are more prudent consumers holding down medical costs and, therefore, health insurance premiums. Second, when people have the choice between higher and lower deductibles, healthy people tend to choose high-deductible policies while less healthy people choose low deductibles. Thus, those who choose high deductibles are a less risky group.

Suppose, however, that an employer with a large group of employees increased the deductible for every member of the group the healthy as well as the sick. In this case, any reduction in total medical expenses would be due solely to changes in the employees' consumption behavior. But even if there are no behavior changes, health insurance premiums can be cut substantially.

The Experience of Large Groups. Many people—including representatives of large employers and large insurance companies question whether there are substantial savings in raising the deductible. On the other hand, the claims experiences of large groups show that substantial savings occur. The reason for the colifusion is that apparently contradictory statements can be made about the distribution of claims. Consider the following statements:

- About 4 percent of the people account for 50 percent of health care spending and 20 percent of the people account for 80 percent of the spending.
- About two-thirds of all health care spending is on medical bills of $5,000 or less.

The first statement, popularized in a widely distributed Blue Cross-Blue Shield publication,[9] implies to many people that most of the money is spent on people who are very sick. By contrast, the second statement implies that most medical bills are small bills. Actually, both statements are correct.

In this case, 50 people spend $60,000, or $1,200 per person on the average. A small percentage of people spend most of the money and at the same time two-thirds of spending is on medical bills below $5,000. If the example were broadened to include a much larger group, the extremes of the distribution would become more evident. A few people would have medical expenses of several hundred thousand dollars, and many others would have no medical claims.

When individuals are given a choice, those who choose a $1,000 deductible rather than a $250 deductible can expect a one-third reduction in health insurance premiums. A one-third reduction in claims costs (and therefore in premiums)[10] is possible for a large group if the deductible is increased from $250 to about $2,500. Considering that higher deductibles cause people to change their behavior, however, a one-third reduction in premiums for a large group will probably occur at a deductible between $1,000 and $2,500.

WINNERS AND LOSERS WITH HIGHER DEDUCTIBLES

Except in those instances where people pay more in premiums than the value of coverage they receive, higher deductibles represent a gamble. On the one hand, a higher deductible results in premium savings. On the other hand, it puts policyholders at greater risk. Thus, some people will gain from a higher deductible and others will lose. A *priori*, most people won't know which group they are in.

The vast majority of people would gain from a higher deductible. In any one year, about 70 percent will have very few medical expenses—accounting for only 2½ percent of all health insurance claims. Those who have large medical bills, on the other hand, will be worse off. Yet as we show below, even people who have high medical expenses in any one year will be better off with a high deductible, *provided they do not have recurring large medical bills over any years.*

Take a leukemia patient, for example, who faces large medical expenses indefinitely into the future. With a high annual deductible, the out-of-pocket costs for this patient simply rise over time.

Yet there are ways of structuring health insurance so that even potential leukemia patients are better off with a high deductible. Instead of the annual deductible which is common these days, health insurance could have a *per condition deductible* as was common earlier. With a per condition deductible, a person diagnosed with cancer would pay the deductible only once, and insurance would pay all of the remaining costs of the cancer treatments—even if those costs were incurred over many years.

ALLOWING PEOPLE TO SELF-INSURE TO HELP THROUGH MEDICAL SAVINGS ACCOUNTS

To help eliminate the perverse incentives in the current system, we should allow individuals to make tax free deposits each year to individual Medisave accounts. These accounts would serve as self-insurance and as an alternative to the wasteful use of third-party insurers for small medical bills. Funds in the accounts would grow tax free, and withdrawals would be permitted only for legitimate medical expenses. Funds not spent during a person's working years could be spent on post-retirement health care or rolled over into a pension fund.

Medisave accounts would be the private property of the account holder and become part of an individual's estate at the time of death. If created by an employer, they would be personal and portable for the employee. Medisave contributions should receive at least as much tax encouragement as payments for conventional health insurance.[11]

Medisave Accounts With a $1,000 Deductible. Most people have no medical expenses in any given year, and it is not uncommon for people to go for several years without incurring medical costs. Medisave balances would grow if not spent in the case of an individual who switches from $250 deductible to a $1,000 deductible, with $400 in premium savings each year. Let's compare benefits of the two alternatives:

- With a $250 deductible and a 20 percent copayment, the policyholder would pay $400 out of the first $1,000 of medical expenses and health insurance would pay 80 percent of the remainder.[12]
- With a $1,000 deductible, the policyholder would be at risk for $600 more each year.
- With a $1,000 deductible and a Medisave account, however, the policyholder could have at least $400 additional cash each year so at worst would pay an additional $200 in medical expenses out of personal funds.
- On the other hand, if the policyholder makes it through the first 18 months without any medical expenses, he is clearly better off with a Medisave account even if he has $1,000 of medical expenses in year two.[13]
- If the policyholder has no medical expenses for five years, he will have accumulated $2,441 in his Medisave account enough to make the Medisave option profitable even if he then has a $1,000 medical expense for each of the next 48 years!

Medisave Accounts With a $2,500 Family Deductible. As noted above, a family in a city with average health care costs can expect to save about $1,749 in insurance premiums if they choose a $2,500 rather than a $250 deductible. Medisave account balances would grow over time if none of the money were spent. Let's compare this Medisave option with a conventional health insurance policy:

- A family with a $250 deductible and a 20 percent copayment (up to $1,000) is at risk for $700 on the first $2,500 of medical expenses in any given year.[14]
- With the Medisave option, the family will have $1,750 in their account the first year, leaving them at risk for an additional $750 only $50 more than under a conventional policy.
- Allowing for interest accumulation, this family will be better off with a Medisave account even if they have $2,500 of medical expenses at the end of each year, every year, indefinitely into the future.

Encouraging Self-Insurance: A Revenue Neutral Proposal. One way to encourage Medisave accounts without any loss of revenue to the federal government is to allow employers and employees to choose higher-deductible policies and place the untaxed premium savings in Medisave accounts.[15] For employees, there would be no change in the amount reserved for health care benefits or in the total tax subsidy for employee benefits. Yet the change would encourage prudence, eliminate waste and give employees greater control over their health care dollars.

Currently, many large employers maintain flexible spending accounts (FSAs) for their employees under Section 125 of the Internal Revenue Code. Under this arrangement, employees can reduce their salaries and make contributions to an indi-

vidual FSAs with pretax dollars. The funds are then used to purchase medical expenses at the employee's discretion. The only difference between an FSA and a Medisave account is that FSA funds are governed by a "use it or lose it" requirement. If employees fail to spend the entire amount in their FSAs in one year, they forfeit the balance.[16] Thus, FSAs create the opposite incentives of Medisave accounts—employees are penalized for not spending FSA funds. A small change in the tax law could change this perverse incentive into a positive incentive: "use it or keep it."

Extending Medisave Accounts to Others: A Non-Revenue Neutral Proposal. Although the federal government grants generous tax subsidies to employer-provided health insurance, only a 25 percent deduction is given to self-employed people who purchase their own health insurance. No deduction is given for the purchase of health insurance by the unemployed, employees of firms which do not provide health insurance or employees who must pay for health insurance coverage for their dependents with aftertax dollars.

Most of the 33 million Americans who lack health insurance have no tax encouragement to obtain it. One of the most effective ways to increase the number of people with health insurance would be to grant a tax deduction (or tax credit) to individuals who purchase health insurance with aftertax dollars. Since the choice to purchase health insurance would remain voluntary, this would create far fewer distortions in the labor market than would employer mandates.[17] At the same time we extend tax encouragement for third-party insurance to all Americans, we should also establish tax incentives to self-insure for small medical bills.[18]

Creating Medisave Accounts in Public Programs. Under the current system, the political pressures governing Medicare (for the elderly) and Medicaid (for the poor) are to expand benefits and refuse to pay for them. One consequence is that most doctors won't see a pregnant woman on Medicaid and there is increasing evidence of health care rationing for other Medicaid services. There is also increasing evidence of rationing under Medicare.

Medisave accounts could solve problems in both programs. For example, pregnant Medicaid women might have an account to draw on which they could freely spend in the medical marketplace. This would empower patients and expand the number of providers to whom they have access. Similarly, the elderly could choose higher Medicare deductibles and make deposits to their own Medisave accounts.

Medisave Accounts in Singapore. Medisave accounts have been in existence in Singapore since 1984. Unlike the proposals made here, in Singapore contributions to Medisave accounts are mandatory—part of the government's program of insisting that people save to meet needs that might otherwise have to be met by the state. Not only are the accounts mandatory, they are the principal form of health insurance in a country that only recently encouraged third-party insurance for catastrophic medical expenses.

ADVANTAGES OF MEDICAL SAVINGS ACCOUNTS

Creating individual and family Medisave accounts would represent a major departure from the current system of paying for health care. These accounts would have immediate advantages which would become even more important over time.

1. **Lowering the Cost of Health Insurance.** Medisave accounts would allow people to substitute less costly self-insurance for more costly third-party insurance for small medical bills. To the degree they are self-insured, people would no longer face premium increases caused by the wasteful consumption decisions of others. And to the extent that third-party insurance was reserved for truly risky, catastrophic events, the cost per dollar of coverage would be much lower than it is today.

2. **Lowering the Administrative Costs of Health Care.** Because we rely on third parties to pay a large part of almost every medical bill, unnecessary and burdensome paperwork is created for doctors, hospital administrators and insurers. By one estimate, as much as $33 billion a year in administrative costs could be saved by the general use of Medisave accounts.

3. **Lowering the Cost of Health Care.** Medisave accounts would institute the only cost control program that has ever worked patients avoiding waste because they have a financial self-interest in doing so. When people spent money from their Medisave accounts, they would be spending their own money, not someone else's an excellent incentive to buy prudently. By one estimate, the general use of Medisave accounts would reduce total health care spending by almost one-third.

4. **Restoring the Doctor-Patient Relationship.** Medisave accounts would give individuals direct control over their health care dollars freeing them from the arbitrary, bureaucratic constraints often imposed by third-party insurers. Physicians would see patients rather than third-party payers as the principal buyers of health

care services and would be more likely to act as patients' agents rather than agents of an institutional bureaucracy.

5. **Giving Patients More Control Over the Services They Are Insured For.** Every group health insurance plan includes some services and providers, and excludes others. But the preferences of the group may not necessarily be those of the individual. In addition, state legislators are increasingly imposing their views on private group policies through mandated health insurance benefit laws. To the extent that individuals were self-insured, they would make these decisions for themselves.

6. **Enjoying the Advantages of a Competitive Medical Marketplace.** In most places, a patient cannot discover the cost of even routine surgery prior to entering a hospital. At the time of discharge, patients are confronted with lengthy, line-item statements not even their doctors can read. Thus, the people who make the purchasing decisions cannot find out what the price is in advance and cannot understand what they were charged afterward. The evidence suggests that these problems are created by our system of third-party payment and are not natural phenomena of the marketplace. When patients pay with their own money (e.g., cosmetic surgery in the United States and most routine surgery at private hospitals in Britain), they usually get a package price in advance and can engage in comparison shopping.

7. **Enjoying the Advantages of Real Health Insurance.** Because third-party insurance pays almost all U.S. medical bills, to a large extent health insurance is not really insurance. Instead, it is *prepayment for consumption of medical care.* One consequence of this situation is that people with preexisting health problems often cannot buy insurance to cover other health risks. A system of Medisave accounts would encourage a market for genuine catastrophic health insurance and would make such insurance available to more people.

8. **Expanding the Benefits of Self-Insurance Over Time.** The funds in most Medisave accounts would grow over time, allowing people to choose higher deductible policies—thus relying less on third-party insurers and increasing their control over their health care dollars.

9. **Creating Incentives for Better Lifestyle Choices.** Since Medisave accounts would last over an individual's entire life, they would allow people to engage in lifetime planning—recognizing that health (and medical expenses) are related to their lifestyle choices. People would bear more of the costs of their bad decisions and reap more of the benefits of their good ones. Those who don't smoke, who eat and drink in moderation, refrain from drug use and otherwise engage in safe conduct would realize financial rewards for their behavior.

10. **Expanding Health Insurance Options During Retirement.** Medisave accounts would eventually become an important source of funds from which to purchase health insurance or make direct payments for medical expenses not covered by Medicare during retirement. Such funds would help America solve the growing problem of long-term care for the elderly.

USING MEDISAVE ACCOUNTS TO LOWER THE ADMINISTRATIVE COSTS OF HEALTH INSURANCE

Health insurance not only creates perverse incentives but its overuse also leads to high and unnecessary administrative costs. For example, the cost of marketing and administering private health insurance averages between 11 and 12 percent of premiums.[19] Dealing with private and public third-party payers also creates administrative burdens for physicians. A study by the American Medical Association estimates that a physician spends an average of six minutes on each claim and the physician's staff spends an average of one hour. Those physicians who contract with outside billing services pay about $8 per claim.[20]

Medisave accounts offer a way of cutting these costs dramatically while at the same time maintaining and even improving the quality of care.

Health Care Debit Cards. A general system of Medisave accounts would lead naturally to the use of health care debit cards. Patients could, for example, pay for physician visits by using their cards just as people now pay for merchandise at retail stores. Several health care debit card companies already exist, including Pulse Card, headquartered in Kansas City, Kansas and Security Plus, headquartered in Newport Beach, California.[21]

With an increase in volume and with increased competition, the administrative costs of using health care debit cards would be quite low, relative to the cost of using third-party payers. Currently, the overhead cost for credit card companies is as low as 1.29 percent. Moreover, for most transactions between patients and physicians, this would be the only administrative cost other than paperwork deemed nec-

essary for purely medical reasons. Private and public insurers would not need additional paperwork except when total costs exceeded high patient deductibles.

Health Care Debit Cards and Medical Records. Health care debit cards could be combined with another technological innovation to reduce other costs and improve the quality of care. Several companies are experimenting with technology that would put a patient's entire medical record on a credit card.[22] This would allow physicians immediate access to each patient's complete medical history. Putting medical records on a credit card could be costly. But it might be less costly than the current system under which physicians treat patients about one-third of the time without access to their records.[23]

The Benefits of the Canadian System Without the Costs. Advocates of the Canadian system of national health insurance cite two principal benefits: (1) patients entering the health care system need produce only a national health insurance card in order to receive care, and (2) the administrative costs of the system are lower because the paperwork is reduced and other costs such as marketing—are eliminated.

Against these advantages, there are severe disadvantages. Because patients are spending other people's money at the time they consume "free" health care, the potential demand is unlimited and Canadian provincial governments control costs by limiting technology and forcing physicians and hospitals to ration health care. As Canadian waiting lists grow longer, there are increasing reports of unnecessary patient deaths and increasing numbers of Canadians crossing the border for U.S. medical care. In addition, because of the perverse incentives the system creates for providers, physicians often over-provide some services while hospital managers try to avoid the costs of acute care by housing chronic patients who use the hospitals as expensive nursing homes.[24]

A system of Medisave accounts plus health care debit cards could produce the benefits of the Canadian system without the adverse side effects. A valid health care debit card would be proof that a patient could pay small medical bills and had third-party insurance to pay large ones. Unlike the Canadian system, however, patients using debit cards would have strong incentives to purchase care prudently because they would be spending their own money.

A BALLPARK ESTIMATE OF THE ECONOMIC EFFECTS OF MEDISAVE ACCOUNTS

A number of studies have compared administrative costs of health insurance in the United States with those of Canada's national health insurance. For example, Table I shows three estimates of the administrative savings that could be realized by adopting the Canadian system as well as an estimate of the costs of eliminating out-of-pocket charges. The potential savings in administrative costs range from a Lewin/ICF estimate of $34 billion to a General Accounting Office (GAO) estimate of $67 billion.[25] However, the effect of eliminating all deductibles and copayments swamps these savings and leads to a net increase in costs.

We believe the estimates of potential savings from reduced administrative costs are much too high for three reasons. First, government accounting practices always lead to underestimates of the real cost of government provisions of goods and services. Second, these estimates completely ignore all indirect costs (e.g., the costs of rationing and of physician and hospital responses to perverse incentives) caused by Canada's method of paying for health care. Third, many of the administrative activities in the U.S. health care system are not designed merely to control spending; they also are designed to prevent inappropriate medical care and maintain quality. The United States is not likely to follow the Canadian practice of giving hospitals global budgets and forcing physicians to ration health care with few questions asked.[26]

Nonetheless, Table I is interesting for a different reason. What the GAO calculates as the rock-bottom cost of administering a health care system is probably on the high side when compared to a system of Medisave accounts and health care debit cards. We used the GAO method to estimate the potential reduction in administrative costs under a system of Medisave accounts and health care debit cards, and the Rand Corporation's method to estimate the likely reduction in health care spending if people had high-deductible health insurance. Table II shows the probable effects of a generalized system under which everyone (including Medicaid and Medicare patients) has third-party catastrophic insurance and uses health care debit cards, drawing on individual Medisave accounts to pay small medical bills. As the table shows:

- A system which combines catastrophic third-party insurance with Medisave accounts should reduce administrative costs by as much as $33 billion.

- **Because the presence of high deductibles would make patients more prudent purchasers of health care, total spending should go down by as much as $147 billion.**
- **After extending catastrophic health insurance to the currently uninsured, the net total savings are $168 billion—almost one-fourth of what the United States now spends on health care.**

Table I.—ESTIMATES OF THE ECONOMIC EFFECTS OF ADOPTING THE CANADIAN SYSTEM IN THE UNITED STATES

[Billions of dollars]

	Lewin/ICF	PNHP	GAO
Insurance overhead	−$22	−$27	−$34
Physician administrative expenses	−1	−9	−15
Hospital administrative expenses	−11	−31	−18
Total	−$34	−$67	−$67
Expansion of coverage for the currently insured[1]	+$54	+$54	+$54
Expansion of coverage for the currently uninsured[1]	+$19	+$19	+$19
Total effect	+$39	+$6	+$6

[1] Based on GAO estimates for increased hospital spending and GAO estimates increased to reflect the Rand results for physician spending.

Source: General Accounting Office, Canadian Health Insurance: ***Lessons for the United States,*** June 1991, pp. 62-67; L.S. Lewin and J. Sheils, ***National Health Spending Under Alternative Universal Access Proposals*** (Washington, DC: Lewin/ICF, October 26, 1990) Prepared for the AFL-CIO; and K. Grumbach et al., "Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal," ***Journal of the American Medical Association,*** Vol. 265, No. 19, May 15, 1991, pp. 2549-2554.

Table II.—ECONOMICS EFFECTS OF COMBINING UNIVERSAL HEALTH INSURANCE WITH MEDISAVE ACCOUNTS AND HEALTH CARE DEBIT CARDS

[Billions of dollars]

Adjustment	Change in Costs	
	Low estimate	High estimate
Savings in Administrative Costs:[1]		
Insurance Overhead	−$8	−$17
Physicians Administrative Expenses	−5	−10
Hospital Administrative Expenses	−3	−6
Total	−$16	−$33
Coverage for the Currently Uninsured[2]	+ 12	+ 12
Behavioral Response[3]	−90	−147
Total effect	−$94	−$168

[1] Based on GAO estimates of the potential savings in administrative costs with the following adjustments. For high estimate, one-half of savings attained in reduced insurance overhead, two-thirds of savings attained in reduced physician administrative costs and one-third of savings attained in reduced hospital administrative costs. For low estimate, one-half of those amounts. See GAO, ***Canadian Health Insurance,*** Table 5.1, p. 63.

[2] Based on GAO and Lewin/ICF estimates. See J. Needleman, et al., ***The Health Care Financing System and the Uninsured*** (Washington, DC: Lewin/ICF, April 4, 1990). Prepared for the Health Care Financing Administration.

[3] Based on Rand estimates. For high estimate, 23 percent reduction in total health care costs excluding insurance overhead, research and public health expenditures. For low estimate, spending is reduced by 45 percent for physicians and 10 percent for hospitals.

CONCLUSION

Primarily because of U.S. tax law, most Americans are overinsured. People use health insurance to pay for non-risky medical episodes, including diagnostic tests and routine checkups. They also use health insurance to pay small medical bills they could pay more economically from personal funds. As a consequence, the administrative costs of the U.S. health care system are much too high and patients and physicians are often wasteful.

Health care costs in the United States could be reduced substantially if people relied on third-party insurance for catastrophic expenses only and paid small medical bills with health care debit cards, drawing on individual savings accounts. No one should be forced to self-insure for small medical bills. But Congress should create the opportunity for people to do so by giving just as much tax encouragement for

deposits to individual medical savings as if currently grants to employer payments for third-party insurance.

ENDNOTES

1. For a more complete discussion of the issued covered in this report, see John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute), forthcoming.

2. Glenn Ruffenbach, "Medical Tests Go Under the Microscope," *Wall Street Journal,* February 7, 1989.

3. Simon Rottenberg, "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation,* Vol. 13, No. 2, Summer 1990, pp. 27–28.

4. See Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, CA: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review,* June 1987. For a survey of economic studies of the demand for medical care, see Paul Feldstein, *Healthcare Economics* (New York: Wiley, 1988).

5. The one exception was vision care, which is not surprising—since eyeglasses are often viewed as a marginal health care expenditure. Sometimes mentioned is high blood pressure, since it was close to being statistically significant. Researchers could find no other significant differences in health outcomes. See Joseph Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine,* Vol. 305, No. 25, December 17,1981, pp. 1501–1507; and Robert Brook et al., "Does Free Care Improve Adults' Health," *New England Journal of Medicine,* Vol. 309, No. 23, December 8, 1983, pp. 1426–1434.

6. The value of the benefit equals 1/(1 –t), where t is the marginal federal income tax rate plus the combined employer-employee Social Security payroll tax rate. For a worker in the 15 percent bracket, t = 0.15 + 0.153. For a worker in the 28 percent bracket, t = 0.28 + 0.153.

7. Unless the policyholders have reached the cap on their copayment ($1,000), they must pay 20 percent of medical expenses above the deductible. Thus, if policyholders with a $1,000 deductible have medical expenses of $2,500 they must pay the first $1,000 plus 20 percent of the next $1,500 (or $300). The insurance company, in this instance, will pay $1,200.

8. These calculations are based on policies sold by Golden Rule Insurance Company, the largest seller of individual and family policies in the country. Other insurance companies sell similar policies at similar prices.

9. Blue Cross and Blue Shield System, *Reforming the Small Group Health Insurance Market,* March 1991, p. 6.

10. Assumes that administrative costs are proportional to claims, which is consistent with the industry's experience.

11. The concept of medical savings accounts was originated by Jesse Hixson, currently a health policy economist with the American Medical Association. The idea first appeared in print in John C. Goodman, Peter Ferrara, Gerald L. Musgrave and Richard Rahn, "Solving the Problem of Medicare," National Center for Policy Analysis, NCPA Policy Report No. 109, January 1984. The idea achieved further impact through John C. Goodman and Richard Rahn, "Salvaging Medicare with an IRA," *Wall Street Journal,* March 20, 1984.

12. The employee's expenses would be the $250 deductible plus a coinsurance payment of $150(20% x $750).

13. Under a conventional policy, the insured would have to pay $400 out of personal funds. When insurance is combined with Medisave funds, however, the insured would have to pay less than $400 out of other personal funds.

14. The family's expenses would be the $250 deductible plus a copayment amount of $450 [20% x ($2,500–$250)].

15. Under the current budget rules, any change in policy proposed in Congress must not cause a net loss of federal revenue. The forecasting techniques used to estimate revenue effects are "static" rather than "dynamic," however. Thus, forecasters tend to ignore any behavioral economic responses that would result from a change in the composition of the total amount of non-taxed employee benefits.

16. See Alain Enthoven, "Health Policy Mismatch," *Health Affairs,* Winter 1985, pp. 5–13.

17. See John C. Goodman, Aldona Robbins and Gary Robbins, "Mandating Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 136, February 1988.

18. For example, individuals might be given a tax deduction for the amount of money that would be necessary to purchase a standard $250 deductible policy. For

the purchase of higher deductible policies, taxpayers could be granted the right to deposit the premium savings in Medisave accounts.

19. According to estimates by Hay/Huggins Company, the "load factor" for private health insurance ranges from 5.5 percent for groups of 10,000 or more to 40 percent for groups of less than five people. See Uwe Reinhardt, "Breaking American Health Policy Gridlock," *Health Affairs,* Summer 1991, Exhibit 1, p. 100.

20. American Medical Association Center for Health Policy Research, "The Administrative Burden of Health Insurance on Physicians," *SMS Report,* Vol. 3, No. 2, 1989.

21. See Burt Sims, "Cutting Health Care Costs: A Major Breakthrough," *US Business to Business,* Winter 1991.

22. Currently, there are three competing technologies: magnetic striped cards, smart cards (with integrated circuits) and optical memory (laser) cards. See C. Peter Waegemann, Patient Cards—The Promise of the Future?" *Medical Practice Management,* Spring 1990, pp. 264–268.

23. Ibid., p. 264.

24. For these and other defects of Canadian national health insurance, see John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991.

25. See General Accounting Office, *Canadian Health Insurance: Lessons for the United States,* June 1991.

26. See Patricia M. Danzon, "The Hidden Cost of Budget-Constrained Health Insurance," paper presented to an American Enterprise Institute conference on "American Health Policy," Washington, DC, October 3–4, 1991.

STATEMENT OF THE OIL, CHEMICAL AND ATOMIC WORKERS INTERNATIONAL UNION

My name is Nolan W. Hancock. I am the Citizenship-Legislative Director for the Oil, Chemical & Atomic Workers International Union AFL–CIO (OCAW). On behalf of OCAW, I submit the following statement to be included in the record of the Senate Finance Committee hearings on single payer health care systems.

Our union represents approximately 100,000 workers employed nationwide in the oil refining, chemical production, pharmaceutical production and nuclear industries, and the corn milling and processing industries.

One of the most critical issues affecting working men and women and their families today is the legislative challenge to improve health insurance coverage and contain health-care costs.

Our union, along with many others in the Labor Community have long supported federal legislation that would assure all Americans access to essential health care services at a price they can afford. Now, organized labor, organized medicine and many in the business community are offering proposals to achieve these same objectives.

We believe the time is right for Congress to take advantage of this growing national consensus and to take the lead in creating a national health care program that will reduce health care costs, expand access to all Americans and improve their quality of health care.

Our present employer-based system that once provided health protection for working Americans, their dependents and retirees, is collapsing around us. These out-of-control health care costs are driving insurance premiums beyond the ability of workers and employers to pay. A study by the AFL–CIO Employee Benefits Department found that in 1990 health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job loss in a strike over health care. Last year 69 percent of all permanently replaced workers had struck over health care benefits as the major issue.

The nation's health care bill is enormous—and it's getting bigger. When other goods and services are exorbitantly and ridiculously priced, we can forego them, however, it is often difficult to forego medical treatment.

In 1987, the U.S. spent 11.2 percent of its Gross National Product (GNP) on health care—that is approximately $512 billion total and represents a $1,926 dollar per capitol expenditure. That's up from 10.9 percent of the GNP in 1986.

According to Consumer Reports (September 1990), in 1990, the nation's medical bill will total some $666 billion, or about $2,664 for every man, woman and child.

One reason we spend so much on health care is that, unlike countries with national health care systems, there is no systematic effort to control how much doctors charge or hospitals spend. Our health care system is profit-driven.

It isn't citizens need to be healthy which comes first, but instead the profit needs of doctors, hospitals, insurance, drug and medical equipment companies. The nation's 1,500 insurance companies are also a big contributor—to rising health care costs. We deny health care to millions, but waste $19 billion a year in industry profits and overhead. In this country, 12 percent of revenues are consumed by overhead versus 2.5 percent in Canada. We waste another $20 billion (1987 figure) for hospital billing and bureaucracy.

Prescription drugs are the same. According to a report released by Senator David Pryor, (D–AR), the price of prescription drugs in the U.S. is substantially higher than the costs of the same drugs in Canada.

With little effort to control costs, over the past decade, insurance industry profiteering and bureaucracy have combined with excess hospital capacity, the skyrocketing costs of physician malpractice insurance, and the growing use of unnecessary medical procedures to send health care costs soaring. Our present system makes the sick get sicker and the poor get poorer.

If the current trends continue, by 1998 workers will be spending 27 percent of their take home pay on health insurance premiums alone.

We are all aware of the appalling figures. There are more than 37 million Americans without health insurance and 53 million additional Americans with inadequate coverage to protect them from a catastrophic illness. Truly one third of all Americans are priced out of adequate health care. The system is broke and cannot be fixed by the band-aid approach. OCAW believes that our health care system needs a major overhaul.

Several legislative proposals are now before this Congress. While these proposals are encouraging in terms of opening up the debate on health care and attempting to rectify some of the current wrongs, they represent a patchwork approach which in most cases fails to confront some of the fundamental problems in our system. And they do not enjoy much support from the public. Whereas 73 percent of the respondents in a current poll supported a proposal for a national health program, only 30 percent supported a program that would only benefit the uninsured. In many proposals, the wasteful- private insurance industry is left intact and the estimated $30 billion squandered annually on the bureaucracy is not addressed.

After meeting with the health care community in the U.S. and Canada seeking a solution to our national health care crisis, OCAW has endorsed the National Health Program advanced by the "Physicians for a National Health Program (PNHP)" which is a single-payer system and is modeled after the Canadian program. We believe that a National Health Program providing cradle to grave coverage is the only solution that makes long-term sense.

Polls in Canada show that 95 percent of the people there are in favor of their NHP, and only 3 percent would go back to the American-style program they used to have. Nine out of 10 Canadians say their health care system is one of the reasons Canada is the best country in the world in which to live. Even two-thirds of Canadian doctors favor their program and physician incomes are among the highest in Canada—four to five times the average industrial wage.

SEE GRAPH BELOW

THE PUBLIC'S VIEW OF THEIR HEALTH CARE SYSTEM IN TEN NATIONS, 1990

	Minor changes needed [1]	Fundamental changes needed [2]	Completely rebuild system [3]	Per capital health expenditure (U.S. dollars)
Canada	56%	38%	5%	$1,483
Netherlands	47	46	5	1,041
West Germany	41	35	13	1,093
France	41	42	10	1,105
Australia	34	43	17	939
Sweden	32	58	6	1,233
Japan	29	47	6	915
United Kingdom	27	52	17	758
Italy	12	46	40	841
United States	10	60	29	2,051

[1] On the survey, the question was worded as follows: "On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better."
[2] There are some good things in our health care system, but fundamental changes are needed to make it work better."
[3] Our health care system has so much wrong with it that we need to completely rebuild it."

THE PUBLIC'S VIEW OF THEIR HEALTH CARE SYSTEM IN TEN NATIONS, 1990—Continued

	Minor changes needed [1]	Fundamental changes needed [2]	Completely rebuild system [3]	Per capital health expenditure (U.S. dollars)

Source: Harvard-Harris-ITF, 1990 Ten-Nation Survey.

We believe a national health program should be a public insurance plan administered by state and regional boards. It should be a single payer program—the U.S. Government. The program should provide all U.S. residents with free health care on demand. This includes doctor visits to a physician of your choice, hospitalization expenses, prescription drug bills, treatment for mental health, long-term illness, dental services, occupational health services, necessary medical equipment and any other health-related expense. In short, a National Health Program would:

- Improve access
- Contain costs
- Minimize bureaucracy
- Cover all Americans
- Provide free choice of physicians, clinics and hospitals
- Abolish discriminatory private insurance

Following is a summary of the Physicians National Health Program which this union supports:

- The most important feature of PNHP's proposal is the removal of all financial barriers to medical care. Every American would be covered for necessary medical care by a public insurance plan administered by state and regional boards.
- Coverage would include standard medical care as well as care for mental health, long-term illness, dental services, occupational health services, and prescription drugs and equipment.
- Patients would receive a National Health Program (NHP) card entitling them to care at any hospital or doctor's office. Patients would not be billed for approved medical care. They would not pay any deductibles, co-payments, or out-of pocket costs. All approved costs would be paid by the NHP.
- Most hospitals and nursing homes would remain privately owned and operated, receiving an annual "global" lump sum from the NHP to cover all operating costs. Global operating budgets would be negotiated with the NHP board. Capital expansion funds would be distributed separately by regional NHP boards on the basis of health planning goals.
- Private doctors would continue to practice on a fee-for-services basis with fee levels set by the NHP board. HMOs would receive a yearly lump sum from the NHP for each patient. They could not retain money they failed to spend on care, thereby removing incentives to skimp on care. Neighborhood health centers, clinics and home care agencies employing salaried doctors and other health providers would be funded directly from NHP on the basis of a global budget.
- The NHP would pay pharmacists wholesale costs plus a reasonable dispensing fee for prescription drugs on the NHP formulary. Medical equipment would be covered in a similar fashion.
- Private insurance which duplicated NHP coverage would be eliminated, saving an estimated $15 billion a year in industry profits and overhead. more than half of the 18 percent hospitals now pay for administration would be saved under this plan.
- The program would be phased in over a three-year period with initial demonstration projects in a few states. During the phase-in period, the NHP would be funded by the same sources that now fund health care. Thus, Medicare and Medicaid would make lump sum payments to the NHP and employers would pay health insurance premiums directly to the NHP.

The program would be federally mandated and funded through the Federal Government. Administration would fall to state and local authorities.

Regional planning would result in more rational allocation of resources and less duplication of equipment. The U.S. currently spends 22 percent of total health care expenditures on administration. Canada spends 12 percent on administration.

A new study on how to restructure the U.S. health care system to provide insurance for all and cut costs was carried out by the "Economic and Social Research Institute," headed by health economist Jack Meyer and commissioned by the Robert Wood Johnson Foundation.

The economic study titled "A National Health Plan in the U.S." concludes the United States would save about $240 billion dollars on health care costs the first year and $4.3 trillion dollars over the next decade if it switched to a Canadian-style National Health Insurance System. The study finds the savings over the decade would be about equal to the entire U.S. Economy in 1991, and that business firms would be among the big winners because their health insurance outlays would be less.

This study concludes that a conversion to a national health care plan would release resources from the health care sector to the rest of the economy. It would transfer money from providers, insurers, and firms that have not been providing health insurance, to employers who do provide insurance, to workers, and to consumers. The report shows that the potential short-term and long term financial savings from containing health care spending are great.

This study as many before it brings one to conclude that the U.S. would be wise to adopt a National Health Care System patterned after the Canadian National Health Care System.

We have reviewed many of the health care bills currently before this Committee and those which have been introduced on the Senate side.

We are especially interested in those bills that provide for the single payer option which we believe is essential to achieve significant savings, and those bills that provide for universal coverage.

We are among those unions who support H.R. 1300, introduced by Congressman Marty Russo, (D--Ill). OCAW also supports S. 2320, introduced by Senator Paul Wellstone. These bills implement most of the key features of a Canadian style National Health Care Program.

CONCLUSION

Our proposals for a National Health Care Program are based on our experience at the bargaining table representing thousands of workers in various industries across America.

Workers are the first to feel the sting of higher health care costs out of their pay checks. They are the ones who are losing access to our health care system that purports to be the best in the world. They are the ones who face the prospect of on the job injury and industrial health hazards, and our members work in some of the most potentially hazardous industries in America. These are decent hard working men and women who are the backbone of America and they deserve as citizens to have adequate health care coverage for themselves and their families.

We are prepared to work with this Committee and its staff, with our membership and their employers, and with coalitions and consumer groups to provide a national health care program for all Americans.

Thank you for the opportunity to have our statement on this important issue included in the Committee's hearing record.

STATEMENT OF THE PATHOLOGY PRACTICE ASSOCIATION

The Pathology Practice Association is a national association of pathologists from private practice, hospitals, independent laboratories, and academia. We appreciate the opportunity to comment on the proposed use of the Medicare Fee Schedule by all payers.

During the 102nd Congress a vast amount of legislation has been introduced to reform the health care system. Many bills offer a comprehensive approach, addressing such key issues as universal access for patients, adequate reimbursement to providers, and maintenance of costs. These are all laudable goals and we support them fully.

However, in this time of severe budget constraints, the Administration and Congress are concerned particularly with ways to curtail the rising cost of health care. Recent discussion has centered on the methods of cost containment, which is also the focus of this hearing. During this debate, some have suggested using the newly established Medicare Fee Schedule (MFS) to determine rates for private payers. We believe this would be a grave error, and could lead to a greatly diminished level of quality health care in this country.

We oppose the use of the MFS by private payers for several reasons. First, we believe at this time, that a discussion of the applicability of the MFS to all payers is premature. It is difficult to understand why Congress would be willing to extend the reach of the MFS to the entire health care industry without studying even the preliminary effects of the MFS on the Medicare system. In the area of pathology

services, there are serious errors in the relative values assigned under the RBRVS and we believe time and experience with the new MFS will prove this to be true.

We believe the Medicare Fee Schedule, which at the time of this hearing is barely five months old, should be allowed time to prove its reliability for containing costs as well as ensuring equitable payment to physicians under the Medicare program before it is taken up by private payers. The Physician Payment Review Commission, whose role is to advise Congress on "reforms of the methods used to pay physicians under the Medicare program," has just released its Annual Report to Congress which includes sound advice on this matter. In the report, the PPRC states: "Further refinements necessary to assure equitable payment to physicians should be made in the Medicare Fee Schedule."

It has been the position of the PPA that the new MFS must indeed be modified if it is to be equitable to physicians.

For this reason, we believe Congress should heed the PPRC and resist any temptation to force the new MFS on private payers. It is very possible that major problems will be uncovered during the transition period which will need to be corrected. In fact that is precisely the reason for phasing in the MFS, to allow the system time for testing and adjustment. Again, we recommend that Congress wait and review the effects of the MFS over the transition period—and act to correct major flaws—before considering its appropriateness for any other payers.

Secondly, use of the MFS by all payers could cripple the pathology profession's ability to attract new people to medicine. For a variety of reasons, not the least of which include numerous changes to pathology reimbursement over the last ten years, a serious shortage of pathologists has been projected by several independent studies.

While we have yet to see exactly how the MFS has impacted our profession, HCFA estimates that pathologists will see a 20 percent drop in their Medicare revenues when the MFS is fully implemented. Were private payers to begin using this schedule as well, in four years many dedicated professionals in our profession may experience a cut in their revenues of double that amount.

The PPRC's recently released report entitled, "optional Payment Rates for Physicians," warns, "current Medicare rates of payment to physicians are knot necessarily the level that should be received from all payers. To the degree that federal policy determines the rates paid by others, consideration of physician incomes will have to be incorporated as well."

We cannot more strongly agree. The PPRC's forecast of the impact which the new MFS might have on physicians if extended to all payers is based on limited data. It does not examine, for example, the specific impact on pathology services. Even where more extensive data has been developed with respect to the RBRVS and the new Medicare Fee Schedule, it is difficult to know for certain what the actual impact will be on physicians, and specifically on pathologists. Without extensive, reliable data, it would be premature and inadvisable to extend the MFS to all payers.

Beyond the devastating impact it could have on our ability to attract new people into the field of pathology, we believe the MFS as presently constituted is simply not the appropriate vehicle for cost containment for private payers. We believe our position is consistent with the findings of the PPRC.

Turning again to the PPRC's report on optional payment methods, the Commission states, "There is little basis to conclude that Medicare rates would be the appropriate level if applied to all payers. . In considering these analyses of private insurers using Medicare rates, an important point to bear in mind is that the overall level of Medicare payment rates is not necessarily the 'right' level. Unlike hospital payment, Medicare physician payment was never tied to a measure of costs." Indeed, Medicare payment rates have been significantly influenced by the condition of the federal budget.

Finally, we would also like to take this opportunity to respond to charges by some who suggest that the reason for the rapid rise in health care costs is the high cost of specialist health services. The United States offers the highest quality health care in the world precisely because of the knowledge and skills of, and advanced technology utilized by, our medical personnel.

Administrative costs and further federal regulations, much like those we are discussing today, impose a heavy burden on the entire health care system. We believe these and a variety of other factors significantly contribute to the high cost of health care in the country. It is much too simplistic to blame rising health care costs on the payments for physician services.

In fact, according to the fall 1991 Health Care Financing Review published by HCFA, in 1990 physician services accounted for only 21 percent of total personal health care expenditures and only 20 percent of total expenditures for health services and supplies under public programs. Controlling that small fraction of total

health care costs by extending a flawed and untested MFS to private payers is simply not going to effectively achieve the kinds of cost containment this committee wants.

If excessive administrative or other unnecessary health care costs can be curtailed by some kind of universal payment system, we strongly, recommend the private sector—including carriers, physicians, and others—be the agents of such a solution, not the federal government. For example, perhaps various parties within a state could reach a consensus on a form of universal payment system which would satisfy the parties within that state. Regardless how such systems might evolve in the future, we strongly recommend against tasking the federal government, for all the reasons cited earlier, with the assignment of developing and administering a payment system affecting health care services not reimbursed by the federal government.

In conclusion, the PPA strongly opposes the use of the MFS by private payers as premature, inappropriate, and ineffective in achieving the goal of cost containment.

STATEMENT OF THE U.S. PUBLIC INTEREST RESEARCH GROUP

Mr. Chairman, the U.S. Public Interest Research Group (U.S. PIRG) appreciates this opportunity to express our support for a single-payer national health care program that provides universal, comprehensive coverage for all Americans under a single, publicly funded program. U.S. PIRG is the national lobbying office for state PIRGs around the country. PIRGs are nonprofit, nonpartisan consumer and environmental advocacy organizations with more than a million members across the country.

We commend Senators Wellstone, Simon, and Metzenbaum for sponsoring S. 2320, the Universal Health Care Act of 1992. This legislation will control the skyrocketing costs of health care, and at the same time, make high-quality health services available to all people in the United States.

THE NEED FOR REFORM

The U.S. is facing a health care crisis. Americans spend more money on health care and receive less in services than citizens in any other western industrialized country.

Ninety-seven million Americans are without adequate insurance to protect them from financial ruin in the event of a serious illness. Of this group, some 37 million have no insurance at all. In addition, millions of other consumers are at risk of losing their benefits if their employer changes insurers, if they become sick, or if they lose or change their jobs.

The average American family will spend $4,296 this year on health care and is expected to spend $9,397 by the year 2000. The U.S. spends more per capital, and a greater proportion of its gross national product (GNP) on medical care than any other nation. Over the past decade, health care spending has grown 60 percent faster than general inflation and now comprises 14 percent of the GNP. Americans will spend $817 billion for health care this year.

Clearly, the current private insurance system is unable to control health care costs, and maintenance of the system will only continue to erode the health and well-being of the nation by denying millions of Americans access to medical care.

ADMINISTRATIVE WASTE

The upward spiral of health care spending is fueled in part by the administrative waste and red tape created by having 1,500 different insurers—each with its own rules and claim forms. The U.S. spends 24 cents on every health care dollar on administration, while Canada's single-payer system costs only 11 'cents of every dollar.

THE SINGLE-PAYER SOLUTION

The single-payer system of health care guarantees universal access to comprehensive, quality health care at a price that Americans can afford. Under a single-payer plan, health care costs of all Americans would be paid by a single, public entity like Social Security or Medicare. The current network of 1,500 different insurance companies would be replaced by a single agency that would pay for all health care services. This agency would not run the health care delivery system, but would replace the inefficient system of paying for health care. The current mix of private and public doctors and medical professionals would remain; the single-payer system would merely simplify the bill-paying process and eliminate the complex and repetitive billing system, which costs consumers billions of dollars a year.

All Americans would receive a national health care card, entitling them to benefits without out-of-pocket expenses. Consumers could go to the health care provider of their choice for treatment simply by presenting the card. Health care providers would be guaranteed payment, and they would no longer alter treatment to fit the insurance status of their patients.

The system would be progressively financed through a combination of corporate and personal taxes. These taxes would replace the premium and out-of-pocket costs now paid by businesses and families. Costs would go down for 95% of the people.

CONSUMERS BENEFIT UNDER A SINGLE-PAYER SYSTEM

A single-payer plan would benefit consumers in several ways:

Saves Money. The General Accounting Office reports that the U.S. could save as much as $67 billion in administrative costs by moving to a single-payer system. Consumers would no longer have to pay out-of-pocket costs, which now account for almost one-quarter of total health care expenditures.

Provides Universal Access and Better Benefits. Under the single-payer system, every American would be provided with benefits they need, including payment for prescription drugs, home- and long-term care, rehabilitative services, vision and dental care, and mental health services. Under the current system, cost-sharing burdens and out-of-pocket costs for prescription drugs and long-term care often create financial hardships and serious obstacles to health care.

Freedom of Choice. The single-payer system would allow every person to seek out the best care available by choosing his or her health care provider at no additional cost. Under the current system, many Americans have little or no say in selecting their health care providers.

Improved Quality of Care. The single-payer system would give every American access to a comprehensive range of services with special emphasis on preventative and primary care. Increased access to prenatal care and early diagnosis of illnesses would improve infant mortality rates and life expectancies for all Americans, and particularly for those millions of people who are presently uninsured or underinsured. The single-payer system would also focus more resources in areas that are underserved by the current system and will create centers of excellence for special treatment procedures to ensure that highly experienced practitioners Provide the best possible care to patients.

Provides Security. Under the single-payer system, no one would be denied coverage due to a pre-existing condition or forced to pay exorbitant premiums because they are considered high risk. The single-payer system would not include such exclusions or discriminatory practices that could result in denial of health care benefits and financial disaster for individual Americans.

CONGRESS SHOULD ENACT A SINGLE-PAYER HEALTH CARE SYSTEM

The cure for America's ailing health care system is a single-payer national health care program. We urge this committee to consider the many benefits of the single-payer system over the current system and to support the reforms necessary to provide comprehensive and affordable health care for all Americans.

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