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HEALTH CARE COVERAGE FOR THE UNINSURED

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

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HEALTH CARE COVERAGE FOR THE UNINSURED

THURSDAY, FEBRUARY 10, 1994

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

The hearing was convened, pursuant to notice, at 10:04 a.m., in Room SD-215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Riegle, Rockefeller, Daschle, Breaux, Dole, Roth, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H-7, February 4, 1994]

FINANCE COMMITTEE HEARING ON HEALTH COVERAGE FOR THE UNINSURED

WASHINGTON, DC—Senator Daniel Patrick Moynihan (D-NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on health care coverage for uninsured Americans.

The hearing will begin at *10:00 a.m. on Thursday, February 10, 1994* in room SD-215 of the Dirksen Senate Office Building.

"It is estimated that 17 percent of Americans lack health insurance," Senator Moynihan said in announcing the hearing. "This is a failure of our insurance system. We will examine the characteristics of the uninsured, the reasons they lack insurance, and hear views on how to remedy this problem."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. May I say to our witnesses and guests that we normally do not begin until we have someone from both sides of the aisle. We are doing a vast emergency legislation for the California earthquakes and things like that, so it will be just a moment. [Pause.]

Good morning. A very special honor to our witnesses, the distinguished Republican Leader has made the necessary bipartisan moment here.

This morning we are going to hear from expert witnesses on the subject of the uninsured, which is surely the concern that animates most of us in this field. As Mrs. Clinton said in Philadelphia just a few days ago, we are confusing the fact that we have the finest physicians and hospitals in the world with the fact that we have the stupidest financing system for health care in the world.

Stupid or not it certainly misses a fair number of people—some 38 million persons at any given time appear to be without health

insurance. This is not a fixed group. It may roll over. I believe all in all most recently we have had in 1992 about 51 million persons who were not insured. That is necessarily a concern to all of us.

It is a concern to the Republican leader, Senator Dole. I might ask you if you would like to make a statement now, sir.

Senator DOLE. No, Mr. Chairman. Thank you.

The CHAIRMAN. Dr. Jensen, Senator Riegle is going to introduce you any moment now. But in the meantime we will just go right ahead with your testimony.

I want to thank Ms. Lyons who will be first in our schedule for changing her arrangements to be here. You flew down from New York overnight, I believe.

Ms. LYONS. From Connecticut on the train.

The CHAIRMAN. Nobody flew. Well, Barbara Lyons is the Associate Director of the Kaiser Commission on the Future of Medicaid. And Gail Jensen, Dr. Jensen, who is an Associate Professor at the Institute of Gerontology and Department of Economics at Wayne State University in Detroit.

Senator Daschle, good morning. Would you like to make an opening statement?

Senator DASCHLE. Good morning, sir. No, I have no opening statement. Thank you.

The CHAIRMAN. I think we have all made that judgment. We would like to hear from you. First, Ms. Lyons.

STATEMENT OF BARBARA LYONS, ASSOCIATE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID, WASHINGTON, DC

Ms. LYONS. Thank you, Mr. Chairman and members of this Committee, for this opportunity to testify on the uninsured and their health care needs. I am Barbara Lyons, associate director of the Kaiser Commission on the Future of Medicaid and staff to the Henry J. Kaiser Family Foundation.

As Chairman Moynihan said, due to unfortunate circumstances Diane Rowland is unable to be here. So I am delivering her statement.

I am pleased to be here to share the results of our analysis on the uninsured in America prepared for the Foundation's health reform project. This analysis is part of a national education campaign that the Foundation has co-sponsored with the League of Women Voters Education Fund to provide the American public with facts on who is uninsured and the impact of lack of insurance.

My testimony today provides an overview of the size and characteristics of the uninsured population and the implications of lack of insurance for access to care and health status.

Lack of health insurance is a problem for millions of Americans and the number of uninsured is growing each year. In 1992, 37 million Americans were uninsured, representing 17 percent of the nonelderly population. Almost all Americans without insurance are under age 65 because the Medicare program provides health insurance to virtually all elderly people.

The 37 million statistic provides a snapshot of the number of uninsured people on any given day. It does not, however, capture the

changes in insurance status that occur over time, as some people gain or lose coverage for part of the year.

If we look over the course of an entire year, over 50 million people, one in five Americans, are uninsured for some period of time. Of these, 22 percent are without insurance for relatively short periods of less than 4 months. Most, however, experience longer periods of lack of insurance. Over one-third, 18 million people, are without health insurance for a year or longer.

Lack of insurance affects people of all ages, income and social classes. But the profile of the uninsured is one predominantly of working Americans and their families. More than 8 in 10 uninsured Americans are workers or dependents of workers. Over half of the uninsured are full-time, full-year workers or their families. Another third come from families of a part-time or part-year worker. Only 16 percent of the uninsured are in families without any attachment to the work force.

The fact that 84 percent of the uninsured come from working families is a product of how health insurance is provided in the work place. Individuals who work for smaller firms are less likely to be covered through their employers.

Because most uninsured Americans are in families with workers, most are not poor. Seven in 10 uninsured are from families with incomes above the Federal poverty level. Most uninsured Americans are, in fact, middle class working families.

Although there are multiple reasons why people are without health insurance, the two major reasons relate to employment and affordability of insurance. Most Americans receive their health insurance through an employer, but not all employers offer insurance.

Therefore, where people work is related to whether or not they will have coverage. Employees of unionized and manufacturing firms are most likely to be covered, while temporary and part-time workers are most often not covered.

Small firms are less likely to offer coverage to their employees than larger firms. Although individuals can also purchase private insurance on their own, the cost of these policies is more expensive then employer-sponsored group coverage and is not affordable to many low to moderate income families.

When uninsured individuals are asked why they do not have insurance the majority report that they cannot afford the coverage or that they cannot obtain it through the work place. For most uninsured Americans lack of insurance is an economic rather than a personal choice.

Not having insurance has implications on how people use health services and ultimately on their health. When people do not have insurance, they have more difficulty accessing the health care system and as a result use less care. They are less likely to visit doctors, especially for primary and preventive care. The uninsured are much more likely than those with private insurance to report that they had postponed seeking care or went without needed care because of financial reasons.

One of the most serious consequences of lack of insurance is that uninsured individuals often seek care later at a more advanced

stage of disease and have higher mortality rates than the privately insured population.

To conclude, health insurance coverage affects individuals, their families, and society as a whole. It affects job decisions and financial security, access to care and people's health. I hope that this profile of the uninsured will help inform your debate on how to provide and pay for health insurance for the 37 million uninsured Americans and the millions more who are at risk of losing coverage.

Thank you.

The CHAIRMAN. We thank you, Ms. Lyons. That was clarifying and succinct, not qualities we always come upon in this field.

[The prepared statement of Diane Rowland appears in the appendix.]

The CHAIRMAN. I note your comment that 3 percent of the uninsured, which would be approximately a million persons, would it not, report they cannot obtain insurance because of ill health or prior illness. Did I get that right, about a million?

Ms. LYONS. About a million people, right.

The CHAIRMAN. That is a good number.

Ms. LYONS. Report that that is the primary reason that they cannot get insurance. Yes.

The CHAIRMAN. Now, Senator Rockefeller, good morning. Would you want to make an opening statement?

Senator ROCKEFELLER. No, only to wish you the top of the morning, sir.

The CHAIRMAN. Good morning.

Well, Dr. Jensen, gerontology is a subject I find more interesting as time advances and I look forward to your comments on the characteristics of the uninsured and the market for health insurance.

STATEMENT OF GAIL A. JENSEN, PH.D., ASSOCIATE PROFESSOR, INSTITUTE OF GERONTOLOGY AND DEPARTMENT OF ECONOMICS, WAYNE STATE UNIVERSITY, DETROIT, MI

Dr. JENSEN. Good morning, Mr. Chairman and Committee members. My name is Gail Jensen. I am an Associate Professor of Economics and Gerontology at Wayne State University in Detroit.

Much of my research over the last several years has focused on the uninsured and employer sponsored health insurance. That is why I was asked to testify here today.

My written testimony deals with the characteristics of the uninsured in America.

The CHAIRMAN. We will place that in the record. You go ahead just as you please.

Dr. JENSEN. All right.

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

Dr. JENSEN. This morning what I would like to do is summarize a few key points about the uninsured using these charts to my left. The number and percent of Americans without health insurance has been increasing. Between 1989 and 1992 the number of uninsured under age 65 increased by 4.1 million.

This increase in the uninsured is a consequence of broader changes in the demographics of Americans, changes in the labor

force which have occurred between 1989 and 1992. In the box I have described a few of the factors contributing to the uninsured.

The percentage of all Americans living in a family headed by a nonworker increased over this period, from 10 percent to 12 percent. This has resulted in 1 million more people being uninsured and being in this category.

The CHAIRMAN. That is the phenomenon we see in the growth of welfare roles, is it not?

Dr. JENSEN. Yes, it is. It is directly related to that.

In addition, more individuals live in a family headed by someone who is unemployed for part of the year. The percentage of Americans in such families increased from 7 to 9 percent of the population. This, too, has resulted in many more people being uninsured.

But in addition to these demographic changes——

The CHAIRMAN. We have gone into a recession here, of course, have we not?

Dr. JENSEN. We have gone into a recession and what we have seen is that the United States has suffered a net loss of full-time jobs. The number of full-time jobs has gone down by over 600,000. But at the same time we have seen an increase, a net increase, of about 1 million part-time jobs.

Since part-time jobs are typically jobs without coverage, this substitution of part-time for full-time labor has resulted in more Americans lacking health insurance.

The next chart, please. Although the uninsured are quite heterogeneous, they disproportionately have weaker ties to the labor market. This chart divides the uninsured into three groups on the basis of the work status of the bread winner in the family.

We see that half of all uninsured persons live in a family where the bread winner works full-time, full-year. Another third live in a family where the family head is a part-time or part-year worker and the rest live in nonworker families.

The next chart, please. The uninsured can be found working in firms of all sizes. What this chart does is it divides the uninsured workers according to the size of the firm they work in. What it shows quite clearly is that the uninsured—it is not just an issue of very small firms that do not offer health insurance. They are found in firms of all sizes.

What this chart does not show is the distribution of the full-time versus part-time by size of firm. But the three slices that are pulled away, those are the segment of firms where full-time, full-year workers work. Those workers are either owners of small sole proprietorships or they are employed full-time by small firms that do not offer health insurance.

The part-time and part-year uninsured are distributed in every slice of the pie and they make up most of the people in the slices corresponding to larger firms. I think this is an important point.

The CHAIRMAN. If I can just—not to interrupt you, but to say, the number of uninsured in firms of more than 1,000 is almost exactly that of firms of 1 to 10.

Dr. JENSEN. That is right. And those workers in the large firms are the part-time and part-year workers. They are ineligible for

health insurance. Virtually all are working in firms that offer coverage to the full-time workers but not the part-timers.

The CHAIRMAN. A good point.

Dr. JENSEN. The next chart, please. The lack of health insurance benefits among some firms is a very small firm issue. This chart looks at firms with 1 to 49 employees and it shows the proportion of firms that offer health insurance. These are firms that are offering the coverage to full-time workers. And about a quarter in each group are offering it to part-timers as well.

But what we see is that the likelihood of offering coverage does increase sharply with the size of the firm, and that the lack of coverage at all is really a phenomenon in the smallest of firms.

It is also the case that the percentage of small firms offering health insurance has not declined over the last few years. Small firms today are as likely to offer health insurance as they were in 1989. And, in fact, the percentage offering coverage has actually increased a little.

But what we have seen in the last 2 years is that small businesses have created more jobs than have large businesses. So when we look at the uninsured on a population basis, because half of these jobs that have been created in small firms are jobs that do not carry benefits, we see proportionately more workers who lack health insurance. But it is not because small firms are not offering coverage. They are as likely as they were a few years ago.

The next chart, please. Proposals to expand health insurance need to consider how well they cover persons who are medically considered to be high risk. They will otherwise prove to be ineffective and not extend coverage to those who have the greatest need for reform.

A very large group of the medically high risk population are persons who are ages 55 to 64. And the uninsured in this age range, there is about 13 percent in this age range who are uninsured. They are at particular risk of incurring catastrophic health care expenses.

But covering this group, this high-risk group, of uninsured persons will be particularly challenging for policymakers for two reasons. First, as this chart shows, the uninsured, ages 55 to 64, have very weak ties to labor markets. Only 35 percent work full-time jobs. The rest are either retired, part-time or they are out of the labor force entirely.

The CHAIRMAN. What is the difference between retired or out of the labor force? Retired has an income, is that what you——

Dr. JENSEN. Pardon?

The CHAIRMAN. What is the difference between being retired and not in the labor force?

Dr. JENSEN. Well, not in the labor force, those would be full-time homemakers and people who simply have not worked in many, many years.

The CHAIRMAN. All right.

Dr. JENSEN. But retired people are people who report, they are self-reported, they report themselves as retired.

The CHAIRMAN. Got you.

Dr. JENSEN. But for this reason, because of these very weak ties to the labor market, most of these high-risk uninsureds would fall outside the scope of an employer mandate.

The next chart, please. It is also the case——

The CHAIRMAN. I am sorry to interrupt, Dr. Jensen. But as I said earlier, Senator Riegle had hoped to introduce you. Now I understand you, Chairman Riegle, have to be at another committee. Would you like to just say a word before you have to leave?

Senator RIEGLE. Mr. Chairman, thank you for your courtesy. I apologize. I am between three committees today. We had an Indian tribe in Michigan that we are trying to get certification for over in the Indian Affairs Committee and we are about to do a mark-up on fair trade and financial services in the Banking Committee, where I serve as Chair, as you know.

I just want to say to Dr. Jensen how much I appreciate the excellent professional scholarly work that you have done and are doing and that you are presenting here this morning. I think this Foundation and the Chairman's interest in understanding what the facts are, in other words sort of penetrating this and trying to understand what the real dynamics of this health care issue look like, is important. The only way we are going to get it right is if we understand the problem.

He is leading that search for us and your work today that you are presenting is of extraordinary value. I am particularly struck, and I will yield at this point, by what you have just said about this group from 55 to 64, the so-called early retiree group or those that have never worked.

They have this higher profile of health needs before they reach Medicare age. What happens to them? That is a very important sort of part of this problem in human terms and dollar terms and we have to make sure that the answer is tailored to meet that group among others.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Chairman.

Dr. Jensen?

Dr. JENSEN. Thank you for your kind words.

It is also the case, now unlike younger persons who lose health insurance, younger persons tend to lose employer sponsored coverage and most of their insurance problems revolve around employer sponsored health insurance.

But among the near elderly, most of the insurance problems, most spells without coverage, have to do with individually purchased health insurance and the problems of noncoverage are not problems that are triggered by changes in employment like the problems of younger age groups.

In fact, among this near elderly population only one in four spells without health insurance is triggered by a change in employment within the household, either retirement, loss of job, et cetera.

Among the near elderly it appears that most problems have to do with individually purchased health insurance. Now this chart, which shows two pie charts, looks at the type of coverage that the near elderly tend to lose and the type of coverage that they regain.

The largest share of the pie in each of these pies is individually purchased health insurance.

The CHAIRMAN. Non-group, private.

Dr. JENSEN. This is non-group, private. It is coverage they buy on their own. What it shows——

The CHAIRMAN. To lose this it could be voluntarily?

Dr. JENSEN. Yes.

The CHAIRMAN. But it also could be, say, they drop you?

Dr. JENSEN. It could be that they dropped their policy. It could be that the insurer refused to renew the policy. It could be that they could not afford it anymore for some reason, that there was a change in household income unrelated to employment.

But what I think it points out is that for a very high risk group of the uninsured population the problems here have nothing to do with employment and they are not going to be solved by an employer mandate. We need to find out why these people are losing individual coverage and correct deficiencies that are apparently present in the market for individually purchased health insurance. That should be a key ingredient of health care reform.

Thank you very much for the opportunity to speak today.

The CHAIRMAN. Thank you, Dr. Jensen. I just note your last point. Would you just expand it a bit? You say an employer mandate would not address the problems you locate in this group called the near elderly. That is because that is not why they lose coverage and that is not how they regain it.

Dr. JENSEN. Well, that is one reason and the other reason is that most of them are outside the labor market—they have no tie to an employer. Most of them are not working full-time jobs or part-time jobs.

The CHAIRMAN. Thank you.

Senator Dole?

Senator DOLE. I just want to follow-up on that. If I am correct here, when you use this world health coverage, I mean, does that include any specific plan or how do you determine who has health coverage and how much and whether they have enough? Is that in your statistics too?

Dr. JENSEN. Well, my statistics are reporting if someone has insurance and they indicate what type they have. Then I have categorized people according to the type of insurance they have. But it is health insurance and it is self-reported health insurance.

Senator DOLE. I think it is right, 84 percent who have insurance live in families headed by someone in the work force, at least 16 percent or about 6 million uninsured live in families where no one is employed. Is that accurate?

Dr. JENSEN. That is correct.

Senator DOLE. The point I make, even if we enacted employer mandates, how do you achieve universality? Hawaii has had employer mandates for some time and according to Census figures they are still only 94 percent covered.

Dr. JENSEN. I do not see how an employer mandate is going to get you universal coverage. You are going to by-pass most of the high-risk uninsured who are near elderly. There would need to be some type of a fall-back government plan for these people. But then, of course, that creates incentives for some employers to change their work force in ways that allow certain people to go into the fall-back plan.

The CHAIRMAN. You mean to layoff the near elderly?

Dr. JENSEN. Yes.

The CHAIRMAN. All right.

Senator DOLE. I have so many figures here. But it is 52 percent of the uninsured or 20 million persons who live in families headed a full-time worker lack insurance because a worker's employer does not provide health benefits. If those insurance costs were fully deductible, it might make a different to the employee.

Dr. JENSEN. Yes, it would.

Senator DOLE. Now, is there a difference between chronically uninsured and this little snapshot that you say that gives us 37 or 38 million? That is the number most often used because it makes it sound maybe more difficult than it is.

But 38 million and the 16 million chronically uninsured both come from the same source, the U.S. Census Bureau; is that correct?

Dr. JENSEN. Yes.

Senator DOLE. And some of these chronically uninsured, well, I guess they do go without insurance for the full year—16 million.

Dr. JENSEN. Yes, that is true.

The CHAIRMAN. Ms. Lyons, if you have a different view you will not hesitate to join in.

Dr. JENSEN. The short-term uninsured, these are people who have a spell without coverage lasting for less than 4 months, most of them are employer or they are between jobs. Whereas, the chronically uninsured, those who are uninsured for a year or more, tend to be persons who have weaker ties to the labor market. Many of them are not in the labor force.

This is particularly true among the near elderly, the people, among the near elderly—I looked at a window 28 months in length and 21 percent of the near elderly had some time without health insurance during that period.

One in four who experienced problems were uninsured for the entire 28 months and the rest were uninsured for only part of the time, typically under 4 months. But the ones who were insured for all 28 months had very weak ties to the labor market.

Senator DOLE. In a recent, Harris Survey done in 1993, 2,000 Americans were questioned. They indicate about a million Americans cannot obtain health insurance because of poor health, illness or age.

Only 7 percent of the currently uninsured told the Harris interviewers they lacked insurance by choice; 59 percent said policies were too costly; 14 percent became uninsured through job loss; and 8 percent said their job provided no insurance.

I think some of the things that are common in all these plans, would address some of those questions.

The CHAIRMAN. Yes. Thank you.

Senator DOLE. Thank you very much.

The CHAIRMAN. Senator Rockefeller wanted to say something.

Senator ROCKEFELLER. No, just an intervention, because I was confused by Dr. Jensen who made, and then, Mr. Chairman, you immediately cleared it up, but it is a classic example of what can happen when you make a statement that is not complete.

You said more or less these words. "A mandate, an employer mandate, will not cover everybody, will not solve the uninsured problem." And then you stopped. Then the Chairman came in and, you know, more or less made the point that obviously the employer mandate is not going to solve uninsured problems for people who are not attached to the work force. I mean, you know, that is about the most obvious thing you can say. That is why you do have a public plan for those who are not connected to the workforce.

Then you indicate that businesses would have an incentive to fire people. Did you say that?

Dr. JENSEN. I think that——

The CHAIRMAN. I suggested it in response to something you did say.

Dr. JENSEN. Well, I think that there would be. If there was coverage available to people, and particularly the near elderly, I think we would see earlier retirement among some people because currently workers are less likely to retire if they do not have insurance and retirement.

Senator ROCKEFELLER. One, we are seeing that today already. I mean, businesses have been doing that, encouraging earlier retirements. You said either one chooses to retire or one is pushed to retire. But the point is, if there is a back-up Federal program there is going to be insurance for that person, no matter what, under the Clinton plan.

Dr. JENSEN. That is right.

Senator ROCKEFELLER. Right?

Dr. JENSEN. That is right. But I think the point I am trying to make is that such a plan would spur some people to retire earlier than they otherwise would.

Senator ROCKEFELLER. And if that is the case, if they make the decision to retire earlier than they otherwise would, then that would be their decision.

Dr. JENSEN. That is right.

Senator ROCKEFELLER. And they would be making that decision based upon the fact that they would also have insurance, non-Medicare, pre-Medicare insurance. All employers would have a mandate and therefore they would all be under the same competitive positions, which presumably would open up a job for a younger worker to move into.

Dr. JENSEN. Yes. But it could also be the case that the size of the whole work force is going to go down.

Senator DOLE. Retire at 40.

The CHAIRMAN. That sounds like your Army period is coming back.

Senator Daschle is next, but I wanted to make a point here, which has never occurred to me. I think it is worth noting, just to keep our proportions here. A large number of employers—this is Dr. Jensen's testimony—have a 3-month probationary period for new employees.

How does that work? So you are uninsured, even though you are employed and are going to be insured

Dr. JENSEN. Yes. Many of the part-time uninsured who have these short spells without coverage are full-time workers who are in a probationary period before becoming eligible. They are new

hires. Firms overwhelmingly have a 3-month waiting period. This is true even among the smallest of firms that offer health insurance. It is a standard. It is also true among self-insured firms.

The CHAIRMAN. Could you give us a proportion involved here? Of our 38 million, how many are on probation?

Dr. JENSEN. How many are on probation? All right, we have—well, a third of all uninsured are in a family where a worker is part-year or part-time and about no more than half—it is more like a third of those—so about one-sixth of all persons are in a family where there is no coverage because the person is a part-year worker.

I would think that many of them are probationary. So I would say an upper bound is a sixth of the uninsured. No more.

The CHAIRMAN. Thank you very much.

Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

I want to thank both of our witnesses for describing the problem and providing such good data. I think we have a pretty good understanding of the scope and complexity of the problem.

The question is, how do we address it. Employer mandate is one approach. Senator Dole rightfully points out that Hawaii has an employer mandate system that only covers 94 percent of its population.

But why would we exempt a good number of people in the enacting legislation that required the employer mandate only to achieve a smaller participation than what we might otherwise have.

Dr. Jensen, you indicated 84 percent of the people who are uninsured are employed. Is that what you said?

Dr. JENSEN. Yes, that is right, they are employed.

Senator DASCHLE. Eighty-four percent are employed.

Dr. JENSEN. They are employed for at least part of the year or part of the time.

Senator DASCHLE. If you have 84 percent that already have a relationship with an employer, and only 16 percent that do not, to build a system around 84 percent of the population would be a pretty efficient way upon which to begin the construction of universal coverage.

As Senator Rockefeller pointed out, finding a way then to insure the remaining 16 percent would be more appropriate than throwing out that 84 percent to then start from scratch to design a system that reaches 100 percent of the population without the employer base.

What is the most efficient system, based upon your experience, of reaching 100 percent universal coverage if it is not an employer based system? What would you do?

Dr. JENSEN. Well, my preferred approach would be a mandate on individuals, a mandate that individuals secure health insurance coverage. I would couple that with a tax subsidy based on risk status and income so that we help out people who are going to find insurance unaffordable.

I believe that under this type of system most employers would continue to offer health benefits because it is a part of the American work place and that is how many workers like it. But I see an individual mandate as avoiding the burden on small business

and I am very concerned that an employer mandate is going to slow down job creation in this country.

Senator DASCHLE. Why would you be more concerned about the burden on small business than you are about the burden on the individual?

Dr. JENSEN. Because I think the burden on the individual we can correct through the Tax Code.

Senator DASCHLE. You cannot do that with small business?

Dr. JENSEN. I am not convinced that you can do it as well.

Senator DASCHLE. But we do that every day, do we not, with all the different tax credits?

Dr. JENSEN. Well, first of all, the start-up costs for a new business are going to be much larger. Small businesses, just as a fact, are very volatile. Half of all small businesses fail. And small firms, if you ask small——

Senator DASCHLE. If you think about it, half the families fail, too, do they not?

Dr. JENSEN. Well, if you ask small firms today why they do not offer health insurance, more than half will tell you that they do not want to commit to the benefit because their profits are too variable.

Senator DASCHLE. I have here one of your figures. Three-fourths of the population who do not have insurance today do not have it for economic reasons.

About a third of business do not offer insurance. I assume they do not offer it for economic reasons. You can make a case on either side, business or individual mandate. It seems to me the arguments on the individual side are far less compelling than those on the business side.

If you talk about the degree of universal coverage acquired through a business or an individual mandate, you find that with auto insurance, an individual mandate, you have about a 22 percent non-participation rate across the country today. So an individual mandate does not give you the kind of universal coverage you can achieve through a business mandate. Just compare auto insurance with health insurance now provided in Hawaii, where we have a 94 percent participation rate.

I appreciate your participation this morning.

The CHAIRMAN. Thank you, Senator Daschle.

If Senator Breaux could withhold just a moment, Senator Rockefeller had another one of those urgent questions.

Senator ROCKEFELLER. It has grown fuzzy in the last 4 minutes.

The CHAIRMAN. All right. We will give you a few minutes to clarify. [Laughter.]

Senator Breaux?

Senator BREAUX. I have a better solution. Let us not mandate it for anybody. Let us fix it first. I want to ask you that question because the Breaux-Durenberger approach really is to provide the insurance reforms to make sure that no one can be denied insurance because of a pre-existing condition or no one would lose it because they changed jobs. And also, no one can lose it because of a catastrophic illness. It could not be cancelled.

In addition to that approach we would take care of people who are poor, who cannot afford coverage by a subsidy program, much

like the President's program, that subsidizes poor people, up to 200 percent of the poverty line.

If you do those things—take care of poor people who cannot afford it; take care of people who are medically uninsurable right now—what are the characteristics of who is not covered at that point in your best guesstimate, I guess?

Our plan is trying to make it attractive so that people want to buy it, and affordable so that they can afford to buy it, rather than demanding something that they may not want. What are your thoughts about what happens when you do those type of things?

The CHAIRMAN. Ms. Lyons?

Senator BREAUX. Anyone. I am sorry.

Dr. JENSEN. Well, as Ms. Lyons pointed out, it is rare that someone is denied health insurance because of their health conditions.

The CHAIRMAN. We have there are 3 percent of those who do not.

Dr. JENSEN. That is right. It is also unusual for firms, even very small firms, to exclude workers from a group plan based on their health conditions.

Senator BREAUX. So if you take care of that small number, even though it is a small number, and you take care of those who cannot afford it by subsidizing the premiums so that they can afford it, then what happens? What is left out there?

Dr. JENSEN. Subsidizing the premium and leaving the choice of whether to offer coverage voluntary is still going to result in firms declining to offer health insurance.

One thing that is always——

Senator BREAUX. Why would they still refuse to offer it?

Dr. JENSEN. Well, there have been a number of studies that have looked at whether more small firms would offer health insurance if we offered them a subsidy and how big of subsidy would it take. And all studies show that even with a 50 percent subsidy, 25 percent of firms that do not offer coverage would still decline to offer it.

Senator BREAUX. And on the other hand you are also suggesting that mandating it may not be a good idea either.

Dr. JENSEN. I am suggesting that mandating it is going to place a huge cost on a segment of the economy that may not be able to bear that cost very well.

Senator BREAUX. I am looking at your Chart Number 11 which shows the reasons why people do not have insurance.

Oh, your chart, I am sorry because I came in late. I apologize, Ms. Lyons.

Your chart that shows that almost 60 percent, 59 percent, of the people who do not have insurance basically do not have it because they cannot afford it. So both the administration's plan and also the Breaux-Durenberger plan all addresses that issue, because we say all right we are going to help you pay for it.

Do you have any thoughts about that? Do we take care of the bulk of the people in your opinion if we have some type of a program that does that?

Ms. LYONS. Certainly we think that the majority of the uninsured need assistance in obtaining insurance financially. That is regardless of what approach is taken. That really needs to be there or people will not be able to obtain it.

Senator BREAUX. So there is an agreement on that part, I think, of the plans that have some type of a subsidy assistance financially to people so they can afford insurance.

Ms. LYONS. Well, we are in the process right now of looking at what the level of the subsidy is and whether it really is adequate to help people who are low to moderate income really obtain insurance. Because I think there are still a lot of unanswered questions out there about what level the subsidy needs to be and what that really translates to people in terms of their income that they have left over.

If people still wind up spending more than 10 percent of their income for their health insurance premiums, even though they are getting a subsidy, that does not necessarily help them to get insurance. So we think the level of the subsidies is real important.

Senator BREAUX. Do you agree that they should pay something if they can afford to?

Ms. LYONS. If they can afford to, I think people can contribute.

Senator BREAUX. There is a reason for that. I mean, not just to get the money, but also to connect with them the cost of health care and to make sure they treat their own selves better so that they can afford their health care. It is a reason for the contribution to connect with them the fact that it is not free.

Ms. LYONS. Yes. Except lower income people have to make a lot of hard choices about what they spend their money on. I think we have to be really careful not to over burden those individuals.

Senator BREAUX. Let me ask one final question and neither one of you may be able to address it because this might not be your area. But if you take care of poor people who do not have insurance, and you take care of people who do not have it because of medical reasons, and then you stop and pause at that point and see if the reforms that we are talking about are starting to work, and do an assessment after those reforms are in place as to who is not yet in the system, do you do violence to the people by pausing before you mandate it?

If you cannot answer because it is not your area, just go ahead and say so. I am not trying to push you into an answer, unless it is the right answer. [Laughter.]

Senator BREAUX. I just tossed it out. If you have a comment, fine.

Dr. JENSEN. I do not think your approach is going to reach many of the uninsured.

Senator BREAUX. Why not? The chart says 60 percent do not have it because they cannot afford it. If you take care of that.

Dr. JENSEN. Well, it all depends on what criteria you use for not being able to afford it. If you say you are going to—even if you provided fully paid coverage for persons in poverty——

Senator BREAUX. Which we do.

Dr. JENSEN. Then you are not going to cover many of the uninsured, because not that many—you know, many are just above poverty.

Senator BREAUX. Well, both plans are up to 200 percent of the poverty line. I do not want to belabor that point.

Thank you.

The CHAIRMAN. On the equal time principle, Senator Dole.

Senator DOLE. We rotate after each Democrat. [Laughter.]

I have all the proxies over here. [Laughter.]

Senator DOLE. I wanted to indicate, I do not think we subsidize automobile insurance. So that is probably why there is 22 percent uncovered. All of these plans talk about subsidizing the low income through vouchers or tax credits.

I think it is much easier to target subsidies to individuals than companies. It is to me much easier. Plus, the President highlighted in his speech, which I thought was a very good speech, about a year ago, the value of individual responsibility.

I think that is a key factor, too, when you get into health coverage and how it is going to be utilized and whether it is going to be overutilized.

But I want to give you a real example. We have Pizza Hut headquartered in Wichita, KS. They have approximately 140,000 part-time employees nationwide. They surveyed 18,000 of these employees—75 percent had coverage. The sources of coverage are 39 percent from their parents; 35 percent from spouses; 27 percent from other sources.

During the survey the 10 percent of the others signed up and 17 percent chose not to get the coverage. If we go to this mandate, depending on the size of the benefit package it is going to cost Pizza Hut between $90–200 million annually which means, even as large as that company is, there will probably be fewer part-time employees. Young people who ought to be working will not have jobs and opportunities. They will be back on the streets and we are trying to get them off the streets.

So I think we do have—this is not the hearing day for employer mandates, but I think it has been raised. I think it has to be addressed. I think all of us have been looking for some way to cover people. Maybe individual mandates will not get everybody either. But this is a real problem for one of the largest companies in our small State.

Senator DASCHLE. Could I ask a question though? If it would cost Pizza Hut $92–200 million—I think that was the figure you used, Senator——

Senator DOLE. Depending on the benefit package.

Senator DASCHLE.—would it not then cost Pizza Hut employees $92–200 million?

Senator DOLE. You mean if they had to pay for it?

Senator DASCHLE. Right.

Senator DOLE. Probably. But there would be subsidies, too, in some cases. So it would not cost employees that much. I think Pizza Hut is too large for subsidies. They would be outside the plan.

Senator DASCHLE. But you still have tax subsidies.

Senator DOLE. I think we will have that debate later on. But we cannot compare automobile insurance to individual mandates because we do not have subsidies. I assume if we subsidize car insurance we probably would get a better percentage. I am not suggesting we do that.

But the point is, I think the testimony has been very helpful and I appreciate it very much.

The CHAIRMAN. Thank you, Senator Dole.

Senator Rockefeller is next. But could I just ask, how many persons are represented as small, sole proprietorship? Ms. Lyons, you mentioned that category, by which we think of the "mom and pop" store, of which there are a lot.

Ms. LYONS. I cannot tell you that right now.

The CHAIRMAN. Someone is trying to help you there.

Ms. LYONS. You want businesses, very small businesses, self-employed people?

The CHAIRMAN. Your phrase was small, sole proprietorships. Well, if you do not have it, perhaps you will get it for us.

Ms. LYONS. We show 14 percent of the uninsured as self-employed and that was, I think, what I said.

The CHAIRMAN. Fourteen percent.

Ms. LYONS. Of the uninsured, yes.

The CHAIRMAN. Thank you.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. I will try to be brief.

The comparison with auto insurance is specious in one respect but it is sort of philosophical in another. The States say you have to have auto insurance. And some people do not get it and they get caught, whatever. There is a reason for that.

In other words, if I do not have it and I run into you in a car I cannot reimburse you. That is not fair to you.

Now, do you consider health insurance to be less important to an individual than auto insurance or do you consider auto insurance to be more important to an individual than health insurance?

Dr. JENSEN. I see the issue you are getting at. Certainly health insurance is far more important than auto insurance. But——

Senator DOLE. If you do not drive, particularly.

Dr. JENSEN [continuing]. If you have a mandate on individuals there is a way to make sure that everyone gets health insurance. That is to have a government-sponsored or State-sponsored fallback plan, health insurance plan, for people who fail to get around to finding a policy.

Then you collect the cost of having that policy in that plan through the Tax Code. When they file that tax return, they are have to show evidence of insurance coverage; and if they do not, then they are assessed the cost of having been in that fallback plan. That is how you reach universal coverage with an individual mandate.

Senator ROCKEFELLER. You are talking about reaching universal coverage through an individual mandate. And what you said earlier, I think maybe one of us said it, that, of course, you have to reform the insurance industry so as to make insurance affordable.

Now let us suppose you do some of these reforms. The Clinton plan suggests pure community rating. The Cooper plan, Senator Breaux's plan, suggest age adjusted community rating, which is discriminatory towards older people. But let us suppose you do that. Now insurance companies are insurance companies. Right? You can say yes to that safely.

And if you adjust them but they still have to make a profit, they are likely to increase their premiums, are they not, each year? You have noticed they do that kind of thing?

Dr. JENSEN. Yes, they do.

Senator ROCKEFELLER. Would it not be useful then if you are really certain that you wanted to get, using an individual mandate, if you wanted to get universal coverage would you not have to sort of almost by definition do what the President does, and that is put a premium cap on what insurance companies could raise their premiums each year by, so as to make sure that those people that you say you want to get covered through individual mandates can, in fact, buy and afford, and then afford to keep the health insurance?

Dr. JENSEN. No, I do not think you need premium caps.

Senator ROCKEFELLER. So you just trust insurance companies?

Dr. JENSEN. No. What you do, what I would do, you allow insurers to use certain criteria for assessing the premium of the policy. You can imagine various characteristics. Everyone in the population is going to be classified according to their risk characteristics. And let us say you order those risk characteristics in premium assessed from lowest to highest and assign them groups—A, B, C, D, E, F, G.

You then allow a tax subsidy based on the risk group whether they are an A, a B, or a C and their income. So you have a tax subsidy that helps out persons who are both low income and who are going to be paying higher insurance premiums.

But you also under an individual mandate, you have something that you do not have——

Senator ROCKEFELLER. Can I interrupt just there? You said subsidize premiums and that would encourage people to buy insurance. But that is not what happens in small business. In fact, in small business—well, it will help some.

But we had a fellow named David Helms here several days ago from the Alpha Center.

The CHAIRMAN. Yes.

Senator ROCKEFELLER. That group had spent 5 years working in 11 States to do just what the Cooper, what the Breaux plan says they want to try. The results were a huge failure. They found that most small employers are not interested in making health insurance available to their workers, even if premiums were 25 percent below the prevailing market rate.

And some of the other studies show that if you subsidize, for a very small business, you subsidize insurance premiums up to 50 percent, that as few as 4 percent of them will go ahead and buy the insurance.

Now, you know, individual behavior, small business behavior, I am not sure how much difference there is. So you are putting a lot of store in saying we can subsidize insurance premiums; and you are also putting a lot of faith in insurance companies that they are not going to raise their premiums.

Dr. JENSEN. Well, I think one key advantage of an individual mandate over employer sponsored coverage is that I think it would give people much greater incentive to make cost conscious choices in their choice of insurance, which they do not have right now. Most people have no idea what health insurance costs and they simply assume—in fact, they tend to pay very small amounts towards their premium as well.

But I think we would see the emergence of more cost effective health insurance plans, and more people enrolling and making cost conscious choices than we do today.

Senator ROCKEFELLER. I give up, Mr. Chairman. [Laughter.]

The CHAIRMAN. Thank you, Senator Rockefeller.

Senator DOLE. Quit while you are behind. [Laughter.]

The CHAIRMAN. I think Dr. Jensen testified that the Alpha experience is the same effect. Did you not?

Dr. JENSEN. Well, I should point out that the studies that the Robert Wood Johnson Foundation has conducted did have some real problems with them because those demonstration plans were not well marketed. Most businesses had no idea that they could get lower cost coverage by enrolling in the RWJ plans.

And, in fact, if you look at all studies that have looked at firm purchasing decisions, their estimates are among the lowest. Studies that look at actual choices to offer in real markets find that small firms are a lot more price sensitive than those studies would suggest.

Senator ROCKEFELLER. Mr. Chairman, could I just make an anecdotal addition?

The CHAIRMAN. Sure.

Senator ROCKEFELLER. I had, along with Senator Dole, a very, very large national restaurant group walk into my office yesterday. They started out, they said about the same thing, this is going to cost us X millions of dollars.

Then I started going through the subsidy program to them. And, you know, they did not know about that. They did not know about that. This goes along with my theory that CEO's generally do not know much about health care for their own companies. They leave that up to somebody else.

He did not know about that subsidy, so that the amount of money they thought they were going to be charged turns out to be a very small portion of that. And as a result of that, they were willing to take an entire new look at the President's plan because of the subsidy.

I find a lot of them really do not understand the President's plan, the Dole-Chafee plan, the Cooper plan, Breaux plan, whatever. They do not understand the plans.

The CHAIRMAN. Unlike the rest of us.

Senator ROCKEFELLER. Sorry?

The CHAIRMAN. Unlike the rest of us.

Senator ROCKEFELLER. Mr. Chairman, you understand all things that are important in this world.

The CHAIRMAN. I do understand that those people from Pizza Hut left Senator Dole's office and then went down to see you. That probably would be right. [Laughter.]

Senator DOLE. Could I just add though to what Senator Rockefeller said? I think even a lot of people understand—I have a lot more faith in business people than he has apparently—but they do understand it.

Senator ROCKEFELLER. The CEO's, just CEO's I am talking about.

Senator DOLE. Well, we have little CEO's in our State. They are regular sized but they have a small number of employees.

You know, it is bad policy, I can show you a lot of farmers in our State who have gone broke with subsidies, and there are some up in South Dakota, too, because they can be terminated, they can be lowered, they can do anything to subsidies. They can be withheld.

And it is bad policy to start down that road. We already have a record in agriculture of 50 years that we ought to look at before we start subsidizing business. I think even though this CEO is probably and exception—where is he from?

Senator ROCKEFELLER. The southern part of the country—Tennessee.

Senator DOLE. Well, in any event I think we need to look at this further.

The CHAIRMAN. We will look at this further.

Senator Baucus is next.

Senator BAUCUS. Thank you, Mr. Chairman.

As I understand it both of you testified that most of the uninsured, that is the larger part of the uninsured, say they do not have insurance because their employer does not offer it and/or because they cannot afford it on their own. Is that essentially correct?

Ms. LYONS. The most frequently reported reason is that they cannot afford it.

Senator BAUCUS. Second, what does that say about using insurance reform solely or primarily as the answer to the health care problems in this country? That is, if we have insurance reform, open enrollment, community rating, et cetera, does this mean that those efforts alone would not significantly decrease the number of uninsured? That is the reasons you gave, because they cannot afford it.

Ms. LYONS. Yes.

Senator BAUCUS. Now if that is the case, then I take it you are both saying that there must be some other mechanisms to deal with the uninsured in addition to insurance reform. And I take you both to say that some kind of mandate is, therefore necessary.

Ms. LYONS. Yes.

Senator BAUCUS. Dr. Jensen, I hear you say that perhaps an individual mandate is a little more appropriate than the employer mandate. You talk about individuals therefore having more choice and more cost conscious, to make the right decisions, because they are participating more in the system. You said something along those lines.

My reaction though is, at least a question in my mind is, will that work because for so many people it just, as you said earlier, they do not buy insurance because it is unaffordable. That is, they do not even reach the threshold of this versus that policy as it is just too expensive.

Dr. JENSEN. Well, that is why you have to help out people for whom it really is unaffordable.

Senator BAUCUS. How do you do that?

Dr. JENSEN. You use the Tax Code. You provide an income-based tax credit or a tax credit based on income and risk, risk category of the individual. I believe that you could design a system where you allowed insurers to use certain rating criteria, have them community rate within those risk criteria.

Then you have people report their risk type on their 1040 so that their subsidy for health insurance is based on both their risk type and their income.

Senator BAUCUS. Before we get to the mechanics, I guess a primary question is at what threshold level, what percent of poverty would you recommend? Because credits for people at 200 percent of poverty, leaves about 15 million Americans or 40 percent of the uninsured would still be uninsured.

Subsidies at 200 percent of the poverty level, will still leave a large number of people uninsured, assuming they all take advantage of the credit. As Senator Rockefeller has pointed out, a lot of people just would not know about it.

Dr. JENSEN. Well, I have not done this analysis. But I would think that if you took the revenue loss that the Federal Government now sees due to the exemption of employer premiums from worker's taxable income that that would be a sizable amount that you could reroute into a tax credit.

I believe that there are some economists who have been working on this very issue.

Senator BAUCUS. So would you raise the level, 200 percent level, to a higher level to get virtually everybody? Because at 200 percent, again, there is 40 percent still uninsured.

Dr. JENSEN. Well, I think what you would do with an individual mandate approach is have a graduated tax subsidy, so that you are subsidizing both the lower income and the higher risk persons.

So I would not simply use, you know, a discrete cutoff, but rather have a subsidy that——

Senator BAUCUS. But I take it, to cover everybody, would you raise it 300 percent, 400 percent? Phase it up to that level for everybody, 100 percent, I mean 1,000, you know, an infinite percent or not.

Dr. JENSEN. No. I do not understand your comment.

Senator BAUCUS. Well, essentially what I am driving at, or attempting to drive at, is that insurance reform is insufficient and we need a mandate. I am trying to pursue the advisability of an individual mandate that you recommend and I am trying to point out that even with an individual mandate, and even with a subsidized individual mandate at 200 percent of poverty, there is still 40 percent uninsured that will not be covered.

Dr. JENSEN. Well, if you have a government fallback plan so that everyone who does not secure coverage on their own automatically goes into either a State sponsored plan or a federally sponsored plan, then that would get you to universal coverage and you could avoid incentives for people to not buy on their own and go into that plan by assessing people the cost of being in that plan when they file their tax return.

So everyone has to end up paying. Everyone ends up paying for health insurance. The other advantage of this approach is that I think it would encourage a lot more retiree health insurance among employers because it would—workers would have a greater desire for that coverage. I think we might see an emergence of more of it.

Senator BAUCUS. Well, that sounds pretty complicated to me, but I hear you. Thank you very much.

The CHAIRMAN. Thank you.

Ms. LYONS. Can I just add one comment to that?

The CHAIRMAN. Please, Ms. Lyons.

Ms. LYONS. The way that you structure the subsidy is very important, particularly for the low-income population because you want to be very careful that as they increase their income that that income is then not taken away and diverted straight into health insurance premiums so that they are really not doing any better for themselves.

The CHAIRMAN. Right. So that any marginal increase all disappears.

Senator BAUCUS. That is a further complication, too.

The CHAIRMAN. Well, why do I not make the suggestion to you as we have done to a number of our witnesses? Why do not you both write up for us your idea of what you would like to see. Will you do that? Sure you will. [Laughter.]

Yes. Thank you.

Ms. LYONS. Thank you.

Dr. JENSEN. Thank you.

The CHAIRMAN. The other thing is, somebody is going to have to decide at what point do you have universal coverage. You do not get 100 percent of anything. Is 95 percent what we are talking about, something like that? I am not making any suggestions.

Senator Roth?

Senator ROTH. I have no questions, Mr. Chairman.

The CHAIRMAN. You are very generous.

Senator Grassley?

Senator GRASSLEY. Well, I have a question, but I bet it has already been asked. I was at the Budget Committee with the Chairman of the Council of Economic Advisors discussing health insurance as well.

Dr. Jensen, it was in your statement where you said only 21 percent of those eligible for COBRA continuation health benefits take advantage of it. I guess I am surprised. To me that is a relatively low figure. Can you tell us why so few take advantage of that opportunity? Because were led to believe, you know, in 1986 I believe it was when we passed that, that that would solve a lot of problems for people that are unemployed, moving jobs, et cetera.

Dr. JENSEN. Well, I think there are three reasons why people do not take advantage of COBRA. One is that for many people who are uninsured, their spell without coverage is short. They may be in a probationary period as a new hire and so they are going to chance it because they know that coverage will be there in just another month or so.

Second, COBRA coverage is expensive. People who become unemployed typically see their earnings fall. So they simply do not want to spend the money because they do not have enough.

And third, the way COBRA is set up, it is actually set up so that an individual, anyone who loses group coverage, can go uninsured for 3 months but still get COBRA coverage if they happen to get sick—they have 3 months to sign up for COBRA and they can sign up retroactively.

So that if they happen to lose their coverage in month one and then in month three they have a heart attack, they then sign up

for COBRA because then they need the insurance to cover the cost. So they sign up and pay retroactively for 3 months. So those three——

The CHAIRMAN. And that is possible under the law.

Dr. JENSEN. Yes, it is possible under the current law.

Senator GRASSLEY. And then a comment, but partly a question as well. As you were answering Senator Baucus's question about individual mandates, I thought that it was just a commonly held belief here that if you have an individual mandate in any of these comprehensive plans as opposed to an employer mandate, that low-income people would have to have a refundable tax credit that would be a voucher for the purchase of that basic plan.

Dr. JENSEN. Yes.

Senator GRASSLEY. Do you not see that as responding to——

Dr. JENSEN. Obviously an individual mandate approach requires a tax credit to help out people for whom insurance is unaffordable and for your very low income that could simply be a voucher with which to purchase health insurance.

Senator GRASSLEY. But under that plan then everybody can be in a comprehensive plan and have that basic plan if they do not have the resources or given the resources to get it?

Dr. JENSEN. Yes.

Senator GRASSLEY. Then you have everybody covered.

Dr. JENSEN. Well, you also need a fallback plan to insure people who——

Senator GRASSLEY. For somebody that is going to fall through the cracks I suppose.

Dr. JENSEN. Well, people who do not get around to finding a policy. There may be some uninsureds who if they do not have to, if no one is saying they—if there is no penalty for not getting insurance, then they will chance it. So you would need a fallback plan and a way of assessing those people, the cost of having themselves in that plan.

Senator GRASSLEY. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Grassley.

Senator DASCHLE. Mr. Chairman, could I just make one comment?

The CHAIRMAN. Of course, Senator Daschle.

Senator DASCHLE. Senator Grassley raised a very interesting question and I think Senator Baucus was making a very important point. There is going to be a subsidy required. And I think his question was, that subsidy now has been proposed in some plans to reach 200 percent of poverty beyond which it terminates. And if that is the termination point, 40 percent of those who are above that level still would not have insurance if the subsidy was a factor in their participation. So we have to find ways of addressing something that goes even beyond 200 percent of poverty.

The Chairman made a point about defining what universal coverage is. That is a very important question for this Committee. Further, the question remains, upon whose shoulders should responsibility for that coverage fall?

While I disagree vehemently with Dr. Jensen's recommendation, she has done the Committee a service by focusing the debate on

whether it ought to be completely the responsibility of the family, which is what she indicates, or whether that responsibility ought to be shared between the family and the employer.

The record may not be clear on this point. The record should show that the Clinton bill would require a mandate of individuals and of employers. It would be a shared responsibility. I think that is a very important distinction.

Thank you.

Senator GRASSLEY. Thank you. I would accept the admonition of the Senator from South Dakota if he would agree that at some point, if it is over 200 percent, at some point above 200 percent there has to be a policy that at some point you do not help and that there is some other factor, exercise in the policy power of the State that has people to have insurance. And at some point you have to have the capability of purchasing that basic plan with all or part of your own resources.

The other thing would be the point that whether it is individual mandate or employer mandate, all of the benefits that go into a package for a worker, whether some of it is insurance or some of it is actual take-home pay, is still a cost of labor. That belongs to the employee, not to the employer.

So eventually with a wage package the employee pays all in the final analysis anyway.

The CHAIRMAN. I think that is something economists would agree on. Well, we have heard some very interesting exchange, I think, among ourselves and we are very much in the debt of Ms. Lyons and Dr. Jensen and we are looking forward to your detailed proposals.

You do not have to worry. Next week we are in recess. So you do not have to think about it. You have all of 7 days.

And now we have another panel. Thank you very much again.

Dr. JENSEN. Thank you for the opportunity to speak.

The CHAIRMAN. It was our pleasure.

We have a panel which I am sure has been listening and will be thinking about the very same subjects. We will take Dr. Jensen's charts down. We have a panel of persons expert and involved in this subject.

Dr. Anne Marie O'Keefe, who is also an attorney, is the Director of Public Health Policy for the Washington Business Group on Health. Dr. Raymond Scalettar. Do I have that right, Doctor?

Dr. SCALETTAR. Scalettar.

The CHAIRMAN. Scalettar, I am sorry. He is a member of the Board of Trustees of the American Medical Association. Gerry Shea, who is director of the Employee Benefits Department of the AFL–CIO. And finally, Phyllis Torda, who is director of Health and Social Policy, Families USA. Good morning to you all.

Dr. O'Keefe, why do we not get started with you.

Dr. O'KEEFE. Thank you very much.

The CHAIRMAN. I think in the interest of time, we are going to ask each of you to keep your testimony to 5 minutes so the questioning can follow.

Dr. O'KEEFE. Thank you.

The CHAIRMAN. Your statements will be placed in the record.

STATEMENT OF ANNE MARIE O'KEEFE, PH.D., J.D., DIRECTOR OF PUBLIC POLICY, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC

Dr. O'KEEFE. Thank you, Mr. Chairman.

The Washington Business Group on Health is the nation's only organization representing large employers solely on issues related to health care. It was created 20 years ago when the member companies began to realize that they were paying more and more for health benefits but were not really sure what they were getting for their money.

Today, WBGH's 200 member companies, mostly Fortune 500's, really are the most knowledgeable and progressive and successful managers of the health benefits that they administer for their more than 30 million employees.

They represent health reform. This happened because they were spending their money and had their worker's productivity at stake. They worked hard. They developed evaluation measures. The negotiated hard and they used their market clout to buy good products.

We are delighted with the opportunity today to share what they have learned. It comes down to organized systems of care. Our member companies discovered that they could not solve the discreet problems in health care—the high costs, the uneven access, the uneven or even unknowable quality—until they fixed the way that services are delivered.

That is why our signature button reads, "It is the delivery system, stupid." OSC's as we call them coordinate and manage care for optimal outcome. They provide comprehensive, cradle-to-grave services relying on integrated medical records, decisions based on good and comprehensive information, constant evaluation, and continuous quality improvement.

And very importantly, OSC's integrate financial risk with responsibility for outcomes. This, by the way, was what we thought the White House meant with their original use of the term "accountable health plans." Although unfortunately, the word accountable seems to have disappeared.

Now to meet the demands of these caring, knowledgeable, informed and invested purchasers, the provider market has organized into systems that sell a quality product. That is really the big news. And also why we at WBGH say that health reform did not begin with this administration. It began and it is ongoing in the business community.

This is also why we ask that the important function that these large purchasers fill be preserved in whatever reform bill you pass. WBGH, like everybody else, wants universal coverage. It is right from a social policy point of view and an economic policy point of view. But there are different ways to achieve it.

What we propose is to build on the best of what we have. The Clinton proposal in its current form would disconnect our large employers from their role as progressive purchasers and remit them instead to the role of passive payers. This was essentially the conclusion of the Congressional Budget Office as well.

With a threshold of 5,000 or even the opportunity to opt out of the regional alliances and with such expensive and onerous re-

quirements to set up a separate corporate alliance, we have found very few companies that would do so.

The CHAIRMAN. Could I ask, of your companies, how many are over 5,000?

Dr. O'KEEFE. Almost all of them.

The CHAIRMAN. Almost all, all right.

Dr. O'KEEFE. And they all, by definition, provide excellent benefits to their workers. I mean, that is why they belong to WBGH.

The way the President proposes to do it would create wrenching change in the health care marketplace. Lewis-VHI estimated that 53 percent of employers would end up paying at least $1,000, more or less, per employee under the Clinton plan.

This is why WBGH respectfully requests that we preserve the role of employers as purchasers. We advocate small market reforms and individual subsidies to provide real universal access. What we have now is not real universal access, not when you cannot afford it, not when you cannot get coverage for everybody in the small group, not when you are paying so much more for administration, not when you cannot get pre-existing conditions covered.

Like the Jackson-Hole group, WBGH recommends a threshold of 100—100 employees for inclusion in regional alliances. This number which is sufficient to spread the risk and beyond which you are not really achieving many more economies of scale.

The members of these pools must have access to good organized systems of care—comprehensive coverage, that is managed and coordinated based on optimal outcome. To make health care affordable, we support subsidies for individuals up to 200 percent of poverty.

The CHAIRMAN. Up to 200 percent.

Dr. O'KEEFE. We recommend that health coverage be decoupled from welfare so that you can work and get health coverage as well. And we advocate insurance reforms, prohibiting insurers from denying or prohibitively pricing for selected individuals or specific conditions. They must report and make available the full range of information that patients need to be wise consumers.

Included in my statement are several other specific recommendations based on what we have learned.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. O'Keefe appears in the appendix.]

The CHAIRMAN. That was very crisp. No wonder you all have 5,000 employees or more.

Doctor, on behalf of the—you are speaking, sir, for the American Medical Association?

Dr. SCALETTAR. That is correct.

The CHAIRMAN. We welcome you.

STATEMENT OF RAYMOND SCALETTAR, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, WASHINGTON, DC

Dr. SCALETTAR. Thank you, Senator. As you have heard, thank you for inviting me. I am Ray Scalettar. I am past-Chairman of the Board of the AMA. I am a member of the Board of Trustees. I am a clinical professor of medicine at George Washington here in town and I practice medicine here in Washington. So I know full well the

problems of the uninsured in this area where we have something like 25 percent uninsured.

I also know full well as a practicing physician the problems of portability, lack of portability, and job lock and what it means to have delay in diagnosis. These are some of the concerns, and major concerns, of the American Medical Association.

We know that when care is not provided that there is earlier death and disability, there is increase in child mortality, and there is a reliance on emergency rooms. For example, in Hawaii we know where there is an employer mandate less usage of emergency rooms are used and, therefore, there is a decrease in health care costs.

The figures that were given earlier as far as the numbers of the uninsured we certainly agree with. It is a serious problem. And physicians have traditionally had responsibility for their indigent patients. But private philanthropies by physicians cannot deal with these social responsibilities and societal problems that we are all confronted with.

In 1990 contemporaneously with the Pepper and Rockefeller Commission Report, the American Medical Association put forth its ideas on Health Access America which provided a framework of our viewpoints. We have modulated this and refined this; and the current version of this providing health care in America is appended to our written statement.

The CHAIRMAN. Oh, good. It will be placed in the record.

Dr. SCALETTAR. Right.

[The report appears in the appendix.]

Dr. SCALETTAR. Basically, we want universal coverage. We think there are many mechanisms and ways to achieve this through an employer mandate such as in Hawaii. We recently modulated our position so that we think an individual mandate can be utilized as well, and suspect that there will ultimately be some type of blending of these two approaches.

We have not backed off from our ideas on employer mandate, however. We also believe that there ought to be medical savings accounts and we think that State risk pools and vouchers may be necessary in any transitional phase.

Physicians must have autonomy to treat patients. They must be the fiduciary of their patients and not a corporate bottom line which we are seeing more and more. The American Medical Association supports and must see to it that there should be quality assurance. We are doing all we can as far as standard setting and we will continue to do so.

Our standard benefit package is also appended and you can see what that includes. We think that this is something that will facilitate portability as one goes from job to job in the future.

We are pleased that the administration's plan does have point of service options so that one can opt out of a specific plan and go to let us say a fee-for-service plan. We think that that is rather important. We concur with tax deductibility of 125 to 133 percent of the gross aggregate premium. We think that small businesses should be subsidized when necessary.

We believe in cost sharing. We think that in order to have prudent purchasing there should be deductibles and co-payments. We

note that health care costs seem to be modulating somewhat in this past year with less increase as compared to previous years. We are very pleased with this.

We think it is very important that we have professional liability reform similar to the California version of the MICRA laws. I think as a practicing physician I cannot tell you how serious this is and how this contributes to the increasing health care cost crisis, if I may.

The CHAIRMAN. Doctor, I did not hear. The California——

Dr. SCALETTAR. MICRA, M-I-C-R-A. That is the acronym.

The CHAIRMAN. It is an acronym.

Dr. SCALETTAR. It is an acronym for the law that went into effect in 1974.

Senator ROCKEFELLER. By which they limit pain and suffering to $250,000.

Dr. SCALETTAR. Yes.

Senator ROCKEFELLER. It is probably the most restrictive in the nation.

Dr. SCALETTAR. Yes. I am glad Senator Rockefeller mentioned that because I think that that is the key facet where we think is so important. This has held down premiums in California because there is this $250,000 cap on pain and suffering or non-economic damages. Because when you go to a jury this is how the awards are meated out and not so much on economic losses, but specifically on the emotional aspects of "pain and suffering."

So we think that this is so important for us to really address this issue. And similarly, the entire concept is so much a part of the practice of medicine whereby more is done because of the fear of liability suits.

I see the light is on. I will just briefly——

The CHAIRMAN. Please, finish your statement.

Dr. SCALETTAR. All right. Thank you, sir.

Anti-trust reform is so important. We must be in a position where we can negotiate. We do not have this ability now. We are concerned with the possibility where we will be accused of anti-competitive behavior. We must have the ability to self-regulate and we are fearful of being sued when we try to do this. We think this is very important.

We must have the ability to negotiate on behalf of quality care for our patients. I must underline this. When physicians are dealing with plans, they may not see eye-to-eye with what we believe is important for patients to have as quality mechanisms. I am not talking about reimbursement, although that certainly is something that we feel we should have a need to be able to negotiate for. But it is extraordinarily important that we can negotiate for quality assurance.

We do not believe that there ought to be global budgets because we think this is going to be a form of rationing. And we think that premium caps is a global budget in sheep's clothing. And we think that health needs, whether they are hurricanes or earthquakes or new tests down the line or tests for colon cancer, we have to have the flexibility to provide these tests to the population.

Again, insurance reform is a must. We must have community rating. I have seen too many of my patients who have been denied

coverage because of pre-existing conditions and therefore are locked into their jobs.

We believe in ERISA reform similar to the type that exists in Hawaii so that there can be a level playing field, so that benefit packages can be equivalent. We do not have this in most of the States at the present time.

Finally, physicians, the American Medical Association, must have the opportunity to be the patients' advocate and not the fiduciary of the corporate bottom line.

Thank you very much.

The CHAIRMAN. Well said, sir.

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

The CHAIRMAN. I wonder if you have had a chance to read Joseph Califano's article in The Post this morning on the Op/Ed page. It says many things you would not agree with and probably all of us would have some differences.

But there is a sentence here which is very important. He says, "At its core health care is a ministry, not an industry." I think that is something to be kept in mind.

Dr. SCALETTAR. Very good. Thank you.

The CHAIRMAN. And Gerry Shea, good morning, sir.

STATEMENT OF GERRY SHEA, DIRECTOR, EMPLOYEE BENEFITS DEPARTMENT, AFL-CIO, WASHINGTON, DC

Mr. SHEA. Good morning, Mr. Chairman, and thank you. I appreciate the invitation to appear before you today and share some from the labor perspective on this question of the uninsured and how we got to where we are.

I have enjoyed listening to the first panel and the interchange between the Committee members and the panelists. Although I must say I did not realize when I signed up for this duty that at the end there might be a homework assignment as the last panel got. [Laughter.]

I guess that all goes with the territory.

But I in a more serious vein want to congratulate you, Mr. Chairman, and all of the members of this Committee for your commitment and leadership on reform. In this topsy-turvy phase of the health policy discussion that seems to have come with the January ice storms, it is heartening to see and to hear your commitment and your leadership. I mean that both for the Committee and the individual members of it.

You have heard in earlier testimony how the problem of the uninsured is largely is largely a problem of working people. I have included in my written testimony some brief retelling of the history of union involvement in negotiating private health benefits. That is, having failed to win the consensus we sought shortly after World War II behind President Truman's proposal. We then entered more and more into what became a bigger and bigger enterprise for us of negotiating private health benefits.

The CHAIRMAN. Yes.

Mr. SHEA. I have it there and I will touch on that today. To underscore the main point that I want to make today, which is that the unions of the AFL-CIO support so strongly the initiatives of

this distinguished body and that the administration has put forward so specifically in the Health Security Act because we believe that we are no longer able to do the job we have traditionally done of negotiating more and more health coverage for more and more workers.

And that in a sense, or in a short statement of the case, we believe that national health reform is essential to preserve what we have been able to accomplish along with our employer counterparts over the past year which is of credit I think to all of those that were involved.

We have seen that the gradual but steady expansion of private health coverage slowed dramatically in the late 1970's and finally stopped in the 1980's, and then at the end of the 1980's we came to the point where less people were being covered who were in the working population.

I make that point first to say that our first traditional role has been to bring more and more workers in, groups of workers, and then perhaps new industries into coverage. And more and more unions in the 1980's all came to a defensive position, not unions only but unions and employers. That is, trying to figure out or preserve and protect benefits that had long been established.

We went through all the cost containment mechanisms and the experiments and so forth. And, frankly, Mr. Chairman, we are not winning that war. That is why we are so strong in terms of our support today.

I put a few statistics in the written document that come from my own home union, the Service Employees Union, that I would like to share with you this morning. The Service Employees has done a sample of a good portion of its membership in terms of health coverage since 1987.

The last time this was done, the last time in 1993, it is a sample of some 400,000 workers, all different kinds of employment—public, private—but they tend to be lower or middle wage workers. I think the average wage in this study was about $29,000.

It showed that the benefits, the premium costs for the family plans had doubled in the period 1987 to 1993 at about $5,500. But what was most upsetting to us was, when we looked at where the distribution of the costs had been and where employer costs in that period had risen 93 percent, I believe, employee contributions had risen over 250 percent.

Now the employer was paying much more in dollar amounts certainly. But the shift was quite dramatic in terms of the increasing burden that was going on the individual. Where the average person in our sample in 1987 was paying maybe 10 percent of the family premium, these are all union negotiated plans, so it would tend to be a little bit higher than the national average, by 1993 the average person was paying 18 percent.

And if you continued that trend, just projected out to the year 2000 without any worsening of the situation, the average member in that 400,000 person sample would be paying 37 percent of the family premium.

If you look at that in terms of after-tax income, that would equate to in the estimate done for the study over 30 percent of the after-tax income of that individual in the year 2000. Of course, this

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is thinking in the year 2000 that the family premium would be in the $10,000 to $15,000 range as is commonly predicted.

But my point, whether you would agree with the specific numbers, is we are looking at something that seriously threatens the income levels of workers and these are unionized facilities. These are not low-wage unrepresented workers. That is the evidence I give to you of my point that we are simply not able to do the job that we have traditionally done.

Then I would just add to that one other fact to consider and I will finish on this point, Mr. Chairman.

The CHAIRMAN. Please.

Mr. SHEA. There is not a local union leader in the country who would not say to you that some point in the recent past they had explicitly traded off wages, that is shaved some amount off this year's age increase, in order to try to protect the health benefits that had already been established. And that was to pay the employer's share.

That was in addition to employees picking up an additional piece of the cost, and it is a serious factor, we believe, in terms of the stagnant wages of middle class working Americans.

So I come to you this morning hoping that our experience can be of some benefit to your deliberations here and with the conviction that we need expeditious action in a comprehensive package of reforms to approach this problem.

Thank you.

The CHAIRMAN. Thank you, sir.

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

The CHAIRMAN. I know that for my part, let this bear witness, I spent the 1980's being befuddled by the fact that clearly productivity was going up and doing well enough, but wages were stagnant. What was going on here? It is not until you begin to see the role that you described in giving up wage increases just to maintain employer benefits and that this has been very much a part of this stagnation, as I think Dr. O'Keefe would probably agree.

We will finally hear from Phyllis Torda, who is director of Health and Social Policy for Families USA.

STATEMENT OF PHYLLIS TORDA, DIRECTOR OF HEALTH AND SOCIAL POLICY, FAMILIES USA, WASHINGTON, DC

Ms. TORDA. Good morning, Mr. Chairman.

Families USA is a national, nonprofit organization that represents consumers on health and long-term care issues. We strongly support the President's goal and his specific proposal to achieve universal and comprehensive coverage for all Americans.

We believe that American families are looking to health reform to provide them with the security of knowing that they will have comprehensive health benefits that they will never lose.

We have heard a lot of statistics this morning. But one that we think best captures the insecurity that American families feel over this issue is that over 2.25 million people lose their health insurance each month in this country.

There are three possible ways of guaranteeing Americans that they will never lose their coverage—through a single-payer system, through an individual mandate, or through an employer mandate.

Families USA has concluded that an approach that includes an employer mandate offers the fairest and most practical way of achieving universal coverage. Let me briefly explain why.

One way in theory to reach the goal of universal coverage is an individual mandate. But in order to make coverage affordable for individuals, significant subsidies would have to accompany such a mandate. Most businesses that do not provide coverage are small businesses, many with low-wage workers.

These are the individuals that can least afford to pay the entire premium for coverage. Without an employer contribution, taxpayers will have to foot the entire cost of adequate subsidies.

Additionally, employers that now provide financial help for coverage may decide to drop their contribution if Federal subsidies are available for individuals. This would in turn increase the total Federal funds needed to make the individual mandate affordable.

An employer mandate is a fair and practical way of reaching the goal of universal coverage. This is the alternative that is least disruptive to the current system. It would not unravel a system that does work for many Americans.

This approach levels the playing field. Most employees are contributing toward their employees' coverage now. Additionally, many employers are paying for the coverage of working spouses whose employers do not want to pay their fair share. Employers who pay for coverage also foot the bill for uncompensated care of those people who are uninsured and who have jobs that do not provide coverage.

I might add here that when Senator Dole raised the issue of the $93 million that it would cost Pizza Hut, that $93 million would be saved by other employers—some of that money would be saved by employers that are currently providing coverage through the spouses of the Pizza Hut employees and by employers who are paying for health care for the uninsured through uncompensated care.

The CHAIRMAN. And that is the cost shift phenomenon.

Ms. TORDA. Right. Exactly.

The CHAIRMAN. So in the end all health care is paid for as Dr. Scalettar would agree.

Ms. TORDA. Exactly.

The employer mandate requires a smaller tax burden than either an individual mandate or the single payer model.

And finally, recent polling indicates that Americans are comfortable with building on the current employer based system with an employer mandate.

A frequently heard criticism of the employer mandate is that jobs will lost if this system is imposed. Yet under the President's bill significant subsidies are given to small businesses and individuals that will need financial assistance to meet their obligations.

For the worker that makes $12,000 a year, for example, the employer contribution equals a 20 cent an hour increase. Increases in the minimum wage at even higher levels have never produced the doom and gloom scenarios of job loss that were predicted.

The goal of comprehensive coverage for all Americans is within our reach. Requiring employees and employers to contribute to coverage can get us to that goal. We look forward to working with you to complete this task.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Torda appears in the appendix.]

The CHAIRMAN. You do not mind my saying that the case about the minimum wage is not yet really resolved because we stopped raising it about 20 years ago, which is another matter.

Senator Daschle?

Senator DASCHLE. I have no questions, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller, you heard some encouraging testimony there.

Senator ROCKEFELLER. Just a question for Dr. Scalettar. There was a long period of time when the American Medical Association—I think it started with their health access plan. I can remember that goes back to the 1980's, the late 1980's when you came up here, and your representatives fighting for an employer mandate. You said as you said this morning that universal coverage is an essential element of health care reform and the employer mandate is the best way for America to achieve that coverage.

The employer mandate, in fact, was the cornerstone of your program, as indeed it is in the Clinton plan. You either do it or you do not. You came up here and your people testified on that and testified on that. It was a decision that was made completely voluntarily, obviously by you all. I think this was your testimony this morning.

"We support a variety of approaches to achieve this goal—an employer mandate, an individual mandate, health, IRA's. As the Congressional debate unfolds, flexibility will be needed in determining the relative responsibilities of individuals, employers and government to ensure universal coverage with a standard set" et cetera, et cetera, et cetera.

It is really quite a remarkable change. I think that you would agree with me, if you and I were talking in private, that health IRA's are a joke. That was kind of like the Bush deal. You could give health IRA's, people can have it and take out a little money stored away. But the problem, as you perfectly well know, is that they do not spend it on health care. They spend it on something else—because they do not have much money. So health insurance purchase goes by the way.

But you specifically endorse health IRA's as an alternative. Now this sort of sudden flexibility of the American Medical Association, when you come up here and you are asking for better malpractice reform, and in the world of give and take if you want that you surely have to give something back. And what you have given back is a very moving, substantial walk away from the cornerstone of your beliefs.

You said, whatever ball game is going on in town, we want to be a part. We want to be at the table. So in a sense you have walked away from the principle that you held for years. And as doctors you know better than anybody the only way you do not have uncompensated care is if you get paid for the services that you give.

This is what the American Medical Association has stood for until suddenly the heat got hot and we got close to the precipice,

and we are close to doing something. I really would like to have an explanation of that.

Dr. SCALETTAR. Yes.

Senator ROCKEFELLER. Number one. And number two, why would the Congress—the Senate, which has 66 lawyers, not all of whom are enthused about the idea of malpractice reform or product liability reform or anything else—why is it that they would sort of bend a sympathetic ear to you as you say we want to have our patients back.

Well, I want you to have your patients back, too. But I want them to be insured when they come to see you. And the way to do that, as Gerry Shea knows, and as Ms. Torda knows, is through an employer mandate. And you know that. And you testified in favor of an employer mandate for years. What happened?

Dr. SCALETTAR. Thank you, Senator. In the first place, you are quite correct. The American Medical Association has been in the forefront for health reform since the mid-1980's. As you may remember we initially had the health policy agenda for the American people and then contemporaneously with your report in February/March of 1990 we came out with Health Access America.

Senator ROCKEFELLER. And we both celebrated the mandate together.

Dr. SCALETTAR. Yes, that is correct. But I think, just as I have heard, the diversity of opinions and ideas in this room and what I hear from Congressmen, you have to realize that our American Medical Association's policies are driven by our House of Delegates, our 435 Delegates throughout the country.

And as they have now begun to hear different ideas and divergent opinions, that there are other ways of achieving this, they, therefore, passed in New Orleans a resolution that stated that we will also support the concept of individual mandates.

We did not sack or back off from employer mandates. We now have an additional one that we can use. Because I suspect ultimately we may have some type of blending. Medical savings accounts in Health Access America was always there.

So I do not think it is fair to characterize it as that we waffled or backed off. We responded to the wishes of the physicians of the United States via the American Medical Association who voted in New Orleans for an additional concept and that is what we have done.

Now with regard to liability reform, I think that when you say that, well, why should we give you this if you are not going to be giving us that, I am distressed to hear to think that this is a quid pro quo.

I think if we are concerned about health care costs, I think we ought to recognize how the system is being driven by professional liability. We pay $9–10 billion in premiums and that is not over the total health care budget, that is over what physicians have to pay from their incomes of $160 billion in gross. So the percentage is considerably higher than that which you will hear from the Association of Trial Lawyers of America.

Similarly, it does not even include what the hospitals have to pay. It does not even address the so-called defensive medicine which Lewin-ICF said in 1991 was approximately $25 billion. This

is what we are confronted with, for example, in any large city, as I practice medicine I have to make judgments, but I cannot make a judgment in an examining room without knowing that there is a trial lawyer in there with me who is going to second guess anything that I do.

So it is not a quid pro quo, sir. It is a necessity to see to it that we can finally be the patients' advocate and have some autonomy in the practice of medicine.

Senator ROCKEFELLER. So that in a sense you are saying that because your Delegates started hearing things—435, that is kind of like Congress, is it not?

Dr. SCALETTAR. Yes, that is exactly right, sir.

Senator ROCKEFELLER. There are about 435 of us and 435 of you.

Dr. SCALETTAR. Yes, 435 Delegates.

Senator ROCKEFELLER. You have, what, about 290,000 members?

Dr. SCALETTAR. Yes.

Senator ROCKEFELLER. And the College of Physicians and the Pediatricians and the American Academy of Physicians have about 300,000 members?

Dr. SCALETTAR. In aggregate I think it is something like that.

Senator ROCKEFELLER. So you represent less than half the doctors in America?

Dr. SCALETTAR. That is correct. However, with a caveat. I think that you should——

Senator ROCKEFELLER. You have some cross membership.

Dr. SCALETTAR. Well, beyond that. We represent 95 percent of the physicians in the country through our House of Delegates because the Academy of Family Physicians, the American College of Physicians and all these other groups are part of our House of Delegates.

Senator ROCKEFELLER. Then explain to me then—I mean, it was very swift the way you kind of pushed it off on the House of Delegates and, therefore, you are kind of helpless you have to represent them. What do you think happened to them?

I mean, if they had been really fighting for this idea, I mean, if you have universal coverage you get paid. Well, the only way you get paid is if you have mandated insurance through the employers in my judgment and the judgment of everybody else, really, all the experts that have testified, not necessarily all the groups that have testified, but the experts in front of the Alliance for Health Reform, they all said the same thing.

What happened to them? I mean, did they just sort of get nervous?

Dr. SCALETTAR. Oh, I think what happened, and I think it is fair to say, Senator, that the debate has really proceeded very expedentially in the last year or two and that there are many more ideas that are percolating that did not in 1990.

I think the concepts of individual mandates have come to the forefront. I think that many physicians, and particularly many of the Delegates, have been lobbied by small businesses in their communities who want them to recognize that they have a problem.

I think it is just fair for you to recognize again that we are a Congress. That it is not just some guys and gals in Chicago who

make policy. That the policy that comes down is from the House of Delegates. It is not me. It is not Lonnie. It is not Jim Todd.

Senator ROCKEFELLER. Well, then let me ask you this. Do you think that the leadership of the American Medical Association—yourself, Jim Todd, others—it has always been my impression that they have favored the employer mandate and they continue to favor the employer mandate. That is my impression, as I know those individuals very intimately as you very well know.

Do you think they just could not win the day, so to speak, with the House of Delegates?

Dr. SCALETTAR. I think it is just as Congress. When there is a freight train coming, we know that it is coming. And we know that there is a democratic process that we have to let play out.

Senator ROCKEFELLER. Which is the freight train?

Dr. SCALETTAR. The freight train is our House of Delegates and they have ideas and their voting was for an individual mandate. I certainly support the democratic process of our Congress, the House of Delegates.

Senator ROCKEFELLER. That is a very fair, safe answer.

The CHAIRMAN. Well, what I want to know is, how do you think you can govern yourselves properly when you have a 435 member House of Delegates, but you have no Senate to give the wiser judgment. [Laughter.]

So you do not rush the lady you just described. I could hear Madison say about that House of Delegates, they hear something on the street corner and the next thing you know they are standing up in the House of Delegates and saying, I just heard something from a guy I met and he must be right.

But over in the Senate the tea is poured into the saucer and cools.

[Laugher.]

Dr. SCALETTAR. Senator Moynihan, some have described our Board of Trustees as our Senate. [Laughter.]

We meet practically monthly and certainly implement——

The CHAIRMAN. And you calm those other people.

Dr. SCALETTAR. We attempt to do that, but we have to implement the policies of the House of Delegates.

The CHAIRMAN. You are evolving as an organization. [Laughter.]

I would like to ask Dr. O'Keefe and Mr. Shea a question. This is a friendly question, although a difficult one. We have to ask it. One of the principal things that economists will agree on, or I believe economists agree on, is that our present tax laws, by allowing employers to deduct as an expense all health care costs and not having employees recognize them in any way in income, provide the wrong signals in the system that it does not cost you. It does not make for the level of cost consciousness that we all find ourselves having to deal with and that you are giving up wages.

Mr. Shea, you and Dr. O'Keefe are all worried about where these costs are going. Senator Chafee and Senator Breaux both suggest that the income tax laws should be changed in this regard. How vehemently are you opposed to that?

Dr. O'KEEFE. That is an issue with which we have grappled and we do want more cost consciousness introduced to the system. Be-

cause on a cost plus, unmanaged, uncoordinated basis fee-for-service, run-a-muck, no management, no oversight, no access to——

The CHAIRMAN. Wow, that is wild. Is that the world out there?

Dr. O'KEEFE. We are pretty strong on that. This system has, indeed, gotten out of hand. But we know that you can provide better care in better managed plans. And our member companies discovered that when you chase quality and use the evaluation measures that you need to measure quality, you bring costs down.

So we do believe in capping the deductibility, not at its present level, which would just build in all the inefficiencies of the current system, but at some level which would drive it toward tighter, more efficient, more cost effective plans.

Our member companies——

The CHAIRMAN. Do you want to give us a number? You do not have to do it this instant.

Dr. O'KEEFE. They have not taken an official position, but they would like to see it pegged at the bottom third of available plans.

The CHAIRMAN. Would you give us a number over the next week of what that would be? You know, what the bottom figure is.

Dr. O'KEEFE. I would be delighted.

The corollary to that which we also think is important is capping the excludability on the consumer side. That is, there is a philosophical and a fairness and a cost consciousness argument to match employer deductibility with excludability from income.

The CHAIRMAN. All right. Mr. Shea?

Mr. SHEA. Mr. Chairman, if the question is how vehemently, if there were a sword here I would be, I think, required to fall on it. I want to answer in two veins.

One is a general economic observation. That is, while we would not have suggested this approach back when this began in World War II with the wage price controls, as I understand the history, we were advocating a different approach at that time—that is, explicitly tax-based financing, a social insurance approach.

The CHAIRMAN. Murray Wagner Dingell.

Mr. SHEA. Precisely. But this practice grew up and as this enormous growth in private insurance coverage took place, which I dare say probably would have astounded the people who were beginning that process back then, and this became such a big tax issue—today as I understand it, bigger than the home mortgage deduction in terms of loss of revenue to the Internal Revenue Service—this is a very significant——

The CHAIRMAN. Dr. Podoff agrees. I had no idea.

Mr. SHEA.—amount of money. It is, therefore, deeply ingrained in the way calculations are made about how Americans are paid. It certainly is a very big factor in terms of the collective bargaining process.

We would be extremely concerned and would argue vehemently against changing this as part of the health reform process because of the potential enormous impact it would have on wage standards and the whole economic condition of Americans.

Having said that, we have accepted with some reservations, but we have accepted the amount of taxation that is included in the Health Security Act. It is after all the Canadian pattern. Since we are great Canadian champions in terms of health design and our

members in Canada are extremely proud and give glowing reports at all of our meetings about how good the Canadian system is and how proud they are of it and how well it works, since they also tax supplemental benefits we find that even though we are included to say no taxation ever, never we have, in fact, accepted that as part of the President's plan.

The CHAIRMAN. The 20 percent?

Mr. SHEA. The 20 percent.

I want to move on to the point about the health care affect though of this, because I think that is perhaps even more central to the debate. One of the reasons that we opposed the approach that a number of other proposals have taken, including Senator Chafee's and Senator Breaux's and Congressman Cooper's is that we believe you could, if you create a very strong economic incentive as some of these plans would do, for going to the lowest cost plan, you will in effect take what has been in a very radical restructuring of Americans actual use of health services. That is their day-to-day accessibility and what they use, a phenomenon that everyone here is familiar with.

I believe or we believe that you will accelerate that enormously and that you run the risk of having, just pushing people into the most restrictive sort of managed care situations.

This idea of tying this to the lowest cost plan in the area we think is extremely dangerous social engineering. It seems like a good design perhaps in a theoretical way and may policy people would advance this, but we think you are really trying with fire.

Certainly the experience of our members is that the amount of change in terms of their actual access to health care over the past few years has been frighteningly large. People are very disturbed about the restriction of choice.

We have so many people who would tell you, not only did it happen to them once or twice, but three or four times, that they had to switch their physician or they had to go to a whole new health plan because their employer got a better offer this year, for very understandable reasons.

And unions have been part of some of this process, because, well, would you take this or would you like to be on strike over this issue. Sometimes we have taken that. We are going to switch from the universal care arrangement to the Blue Cross arrangement because they offered us a better deal this year.

And yet it means that members wind up wholesale changes unless they are going to take the money out of their pocket and pay for this health care on their own.

That has built a reservoir of concern and fear. That is part of what is being reflected today in what I believe is a general wariness among the population about what is change going to mean for us.

We are doing it. We have finished—today in Seattle we are doing a big education program with local union leadership. Fifty-nine of these programs since Christmas. Training programs the AFL–CIO has done all around the country, anywhere from 50 to 250 local union leaders come in, spend 3½ hours talking about the Health Security Act and all the proposals.

Mostly it is to try to give people some basis for their political judgments about health reform. But what we find is that people are deeply, deeply concerned on a personal basis about what is this going to mean to me and my family.

And that underlying concern, I think, begins with your experience over the last few years in terms of how they feel like they have been pushed around in the health system.

The CHAIRMAN. Well, you made the point that the most common issue on which the Service Employees have gone on strike has been health care benefits.

Mr. SHEA. And other unions as well.

The CHAIRMAN. Dr. O'Keefe, do you want to comment?

Dr. O'KEEFE. Well, I could not agree more. It is probably the most important personal issue in all of our lives, which is what makes this so unique. I mean, it is the biggest economy in the country and it is also the most important personal issue.

But I have to point out that more expensive care does not equate to better care. We know that the most efficient systems that are the best organized and use the best information and make the wisest decisions based on outcomes are frequently the most inexpensive care; and Mayo Clinic is a perfect example of that.

If your choice is to ask to move from your local hospital across the street that does two coronary by-passes a year to a system on the order of Mayo Clinic, which is extremely experienced and cost effective, then that is a pretty good choice.

The CHAIRMAN. I have an uninformed view, but even so, when you have an era of discovery such as we are going through in medicine, you will have a continued advent of something new which will be hugely expensive and then will gradually be regularized.

All over this country we have empty hospital beds because medicine has gotten better. You probably agree with that, do you not?

Dr. SCALETTAR. I agree with that and I think that is why it is so important to recognize that new technology is coming. I alluded to the colon cancer test which is suggested that it will cost something like $500 to $1,000 when this is available, which will determine your DNA structure, whether you are susceptible to it, and therefore you may wish to have a colonoscopy more often. This is very important.

But I did want to make just two points. One is with regard to what Mr. Shea stated about the employees being moved around from plant to plant. This is a stark reality and this is happening every day.

The human dimensions of this are unbelievably bad, because we are seeing patients who are losing their physicians. They are being buffeted around like ping pong balls from doctor to doctor because their plans change and they no longer have the doctor-patient relationship. The physicians have to get their records, have to analyze it. It is a costly process that is occurring.

And finally, with regard to reimbursement, I think that some allusion was made to perhaps there may be some extravagance in some of the charges. But I think a new approach which we are certainly trying to get across is utilizing the concept of the resource-based relative value system in the private sector, which is currently being utilized for governmental programs such as Medicare.

We think that when we have adequate input into the mechanism that this would be a way to see to it that there is fair reimbursement and there is not anything that would be overcharging of any patients. And it is an appropriate mechanism.

The CHAIRMAN. Ms. Torda, just a last question. Do you at Families USA find that this issue of being moved from plan to plan, has come up on your screen?

Ms. TORDA. Oh, absolutely. I was just thinking that when some members of the Senate have suggested that there might not be a crisis, I do not know how you measure it. I do not know any objective way to measure what Dr. Scalettar just described. But clearly that is very disruptive to individuals in the health care they get and causes extreme dissatisfaction with our current system and something that people want fixed.

The CHAIRMAN. Mr. Shea?

Mr. SHEA. Thank you, Mr. Chairman.

I just wanted to add, I do not want to be have found later to have averted this down a different path than the Chairman intended to go with your question. That is why I will say the following, which is that my point is not that the kind of change that we have had in the last few years is unacceptable.

We are, indeed, trying to deal with an enormously complex system. And we have the scientific evidence, I think, as Dr. O'Keefe would say, that we clearly know more expensive is not better and that the kind of choice that people get, that is open up the Yellow Pages or ask your coworker or ask another member is not a very informed choice in terms of how to select, how to answer often very scary questions about ourselves.

I want to make the point that we have to be careful that this process does not get out of hand. One of our concerns about the tax cap question is that if you use that heavy a club in terms of this process, you are likely to accelerate this in a way where the choices will not be all Mayo Clinic I or Mayo Clinic II.

But Lord knows, and more like the kind of choices we have seen in California between Group A that got bought by Group B, but then went out of business because their financing was not so good. And so somebody else now has to come in and take over the whole thing.

It is an acceleration of this process that I think we have to fear and we have to manage the change in the delivery system operation, taking into account both the need to make enormous change and downsize the system, and also people's sensitivities and just their human experience.

It is the combination of that trend and the idea of a major taxation piece, not supplemental but something that would really start to get into the basic package or it would really be a basis of choice between Plan A and Plan B that we think could set off a very detrimental trend and not incidentally stir up a kind of opposition at the grassroots to this kind of a change.

The CHAIRMAN. To this kind of change? But in the budget estimate for 1995, for tax expenditures which we began working in about 1960—the exclusion of employer contributions at $56 billion is number one. I thought about third. Sorry, I did not know this. The deductibility of mortgage interest is a mere $54 billion.

I would like to let Senator Rockefeller have the last word. But before I close off, I just want to say to you all, thank you, of course, and that whatever we do we have to keep in mind the dynamism of medical science today.

Doctor, you mentioned a colon cancer test which would involve a judgment about DNA. Well, I think it was this last Monday, or was it Monday a week ago, that in the large Rockefeller rooms of Rockefeller University, that David Rockefeller was present for a little champagne reception for Dr. McCarty, the surviving member of three persons who 50 years ago last week published in a journal I never heard of the chemical composition of DNA.

When that happened, the culture changed. I mean, we were on our way to where we are at this moment. That is the hugely exciting thing that is going on. That is why we want to make sure it continues to go on. Although how you guarantee things like that, I do not know, either culture brings them or it does not.

Senator Rockefeller, do you not want to say something nice about the Rockefeller University? [Laughter.]

The CHAIRMAN. You never took the course, did you?

Senator ROCKEFELLER. I did not. Although I will have to say, Mr. Chairman, I am very proud of the role that my family has taken over the last number of generations, not just what used to be the Rockefeller Institute, now the Rockefeller University, but the ratification of hookworm, of schistomiasis in southern parts of our hemisphere, and also introduction for the first time of western medicine into China.

So I am pleased that you mentioned that and it brings some nice thoughts to mind.

The CHAIRMAN. With that pleasant thought, indeed, we want to thank you very much for coming. You have been very helpful to us. Dr. O'Keefe, you owe us a little information on what the lower third would be. We will check it with Mr. Shea and if you both agree then we know we have learned something.

Dr. SCALETTAR. Thank you, sir.

The CHAIRMAN. Doctor, thank you, sir.

Ms. Torda, thank you.

[Whereupon, at 12:27 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF GAIL A. JENSEN

This statement briefly discusses: (1) who is without health insurance in the United States, (2) how long people are without it, (3) the nature of noncoverage among the near elderly—a medically "high risk" subpopulation, (4) employer-sponsored retiree health benefits among persons ages 55 to 64, and (5) the lack of job-based insurance among small firms, where many of the uninsured work.

CHARACTERISTICS OF THE UNINSURED

The number of Americans without health insurance is increasing. Estimates from the Current Population Survey (CPS) indicate that 17.4 percent of the nonelderly population, or 38.5 million people, were without either private or public health insurance in 1992. This compares with 16.6 percent (36.3 million) in 1991, 16.5 percent (35.7 million) in 1990, and 16.1 percent (34.4 million) in 1989 [Employee Benefit Research Institute (EBRI) 1994]. These statistics are intended to include only individuals without coverage for the entire 12 months in each year. Many researchers, however, believe that most respondents actually answer the CPS health insurance questions with reference to a particular point in time or some period less than the full year, in which case these statistics more accurately reflect noncoverage at a point in time. Nonetheless, many persons experiencing short periods without health insurance are not counted in the numbers.

Although the uninsured are quite heterogeneous, they disproportionately have weaker ties to the labor market than insured persons. Just over half of the nonelderly uninsured are working adults (57 percent), roughly one sixth (18 percent) are nonworking adults, and one-quarter (25 percent) are children. However, many of these nonworking adults and children are part of families headed by a worker. In all, about half (52 percent) of the uninsured live in families headed by a full-time full-year worker (i.e., a person who works 35 weeks or more during the year and works 35 hours or more in a typical week). Another third of the uninsured (32 percent) are in families headed by someone who works either part-time or for only part of the year, and the rest (16 percent) are in families headed by a nonworker. In contrast, the large majority of insured persons (74 percent) belong to families headed by a full-time full-year worker, and fewer are in families where the head works less than full-time (15 percent) or not at all (11 percent).

Among the uninsured who do work, employment is nearly always such that the worker lacks access to employer-sponsored coverage, either because he or she is ineligible to participate in the employer's plan or because no plan is offered. Very rarely do workers turn down an offer of employer health insurance benefits and remain uninsured. (Only 2 percent do so [Long and Marquis 1992].) As noted, many of the working uninsured work less than full-year full-time. Specifically, 13 percent work part-time throughout the year, 13 percent work for only part of the year, and a quarter (26 percent) are unemployed for some period. We know that part-time employees are routinely excluded from participating in employers' group health insurance plans, and that workers who are just beginning a job usually face a waiting period before becoming eligible to join a company plan [Bureau of Labor Statistics (BLS) 1992; Gabel et al. 1994]. Thus, these two reasons may account for a substantial amount of noncoverage among uninsured workers.

The uninsured are also concentrated in sectors of the economy where employer-sponsored insurance is less common. Small businesses, which are much less likely to provide workers job-based health insurance, employ many of them: More than a third of uninsured workers (35 percent) are employed by a firm with fewer than 25

employees, and another 16 percent are employed by a firm with 25–99 employees. In addition, 13 percent are self-employed, typically owners of small sole proprietorships. The high cost of individual health coverage faced by many self-employed persons, and the less favorable tax treatment of their insurance premiums (relative to incorporated firms) make it difficult for the self-employed to purchase coverage for themselves and their families.

Uninsured workers are also characterized by relatively low earnings. A full half (50 percent) earned under $10,000 annually in 1992, and another third (32 percent) made more than that but less than $20,000. By comparison, only 23 percent of insured workers made less than $10,000 and the same number (23 percent) made $10,000 to $19,000.

The demographics of the uninsured differ in important respects from the population as a whole. Whereas less than a third of the total population (31 percent) live in single-adult or single-parent households, these two categories describe nearly half of the uninsured (45 percent). While 46 percent of the total population live in two-parent households with children, only 35 percent of the uninsured fit this description. The remaining 20 percent of the uninsured live in married households without children, which contrasts with 23 percent among the broader population.

Two-fifths (41 percent) of the uninsured are minorities (either Black, Hispanic, or another nonwhite racial group), compared to only a quarter (26 percent) within the broader population. The uninsured are also less educated. Nearly three-quarters (69 percent) are in households where the family head has no education beyond high school—a much higher rate than in the broader population (51 percent). By age and sex, uninsured nonelderly adults tend to be young and more often male. A quarter (25 percent) are 18 to 24 years old, and 56 percent are male, which compares with 16 and 49 percent, respectively, among all Americans ages 18 to 64.

LENGTH OF TIME WITHOUT HEALTH INSURANCE

The number of persons who were uninsured in each year, reported above, are underestimates of the number of Americans who actually experienced some time without coverage in those years. Many individuals experience spells without health insurance that last only a few months and such persons are overlooked in the numbers. The Survey of Income and Program Participation (SIPP), which gathers data on the changing circumstances of persons over time, shows that during a 28 month period in 1985 to 1987, 63.4 million persons (or 28 percent of the U.S. population) lacked health insurance for at least one month. This was approximately twice the number of persons who lacked health insurance at a point in time in 1986 (specifically, the fourth quarter) when 33.5 million persons (or 14 percent of the population) reported no coverage. Half of all uninsured spells (50 percent) end within 4 months, and another 17 percent end within 5 to 8 months. Considering all uninsured spells, 30 percent last more than a year, and 15 percent last more than two years [Nelson and Short 1990; Swartz and McBride 1990].

People who are employed when an uninsured spell begins are very likely to have a short spell. For more than half (54 percent) the spell ends in less than five months. People who lose employer coverage but who are still working have a 3 in 5 chance of regaining insurance within 4 months. This observation is consistent with data on the probationary period for coverage often set by employers. Most set a three month wait before allowing full-time workers to join the company plan. Persons who are unemployed when their spell begins are also likely to have a short spell but more have spells lasting between 5 and 8 months. People who are out of the labor force are most likely to have an uninsured spells lasting more than 2 years—one in five will experience a spell lasting this long.

Although most uninsured spells involve a loss of employer coverage, few persons take advantage of COBRA, the 1985 federal law that allows employees and their dependents separated from an employer plan to continue group coverage for 18 or 36 months (depending on their circumstances), provided they pay the group premium themselves. Only one in five persons (21 percent) who are eligible for COBRA elect such coverage [Flynn 1992].

INSURING THE NEAR ELDERLY: A MEDICALLY HIGH-RISK POPULATION

Persons especially vulnerable to incurring very high health care expenses are the uninsured who are medically considered to be "high-risk." Proposals to expand health insurance need to take into consideration how well they cover high-risk individuals. They may otherwise prove to be ineffective and not extend protection to those individuals who stand to benefit most from reform. One large and easily identifiable segment of the nonaged medically high-risk population are the near elderly (persons 55 to 64 years of age). By almost any measure persons in this age range

face a much higher risk of illness. This fact is most obviously reflected in data on health insurance claims by age group, but is apparent from other statistics, as well. Persons 55 to 64 years of age, for example, account for two thirds of all deaths among adults under age 65, and more than one-third of all surgeries and hospital days within the same population [National Center for Health Statistics 1988].

Insuring the near elderly under health care reform may pose special problems for policy makers for three reasons. First, persons in this age range maintain only weak links with the labor market, particularly the uninsured in this cohort, making it likely that most would fall outside the scope of an employer mandate to provide coverage. Second, many of the near elderly now receive retiree health insurance from a former employer, yet employers' incentives to provide such coverage for future retirees could be greatly diminished under some reform proposals. Third, many of the insurance problems of the near elderly appear to arise in the market for individual coverage, unlike the problems of younger persons, which are more often associated with employment and job changes. The market for individual health insurance has not been studied to determine whether the functioning of this market is deficient in ways which can be corrected under health care reform.

CPS data show that in 1992, 13 percent of the near elderly (or 2.7 million persons) lacked health insurance [EBRI 1994]. While slightly lower than the percent uninsured in younger age groups, this rate is disturbing given that persons in this age range are especially vulnerable to catastrophic health expenses. Just under half (46 percent) of the near elderly have employer coverage as active workers or as dependents of workers, 18 percent have group coverage through a former employer, 13 percent have individually purchased insurance, and 17 percent have either Medicare or Medicaid. One reason often suggested for being uninsured is that the person sees no need for insurance. This should not be the case for this age group; noncoverage is not likely to be a voluntary choice made by the individual.

The 13 percent of the near elderly who are uninsured, based on the CPS, does not reflect the many persons in this age range who have brief spells of noncoverage. More than any other age group, the near elderly tend to experience short periods without health insurance, typically 4 months or less. Over a two and a half year period that spanned 1983 to 1986, a full 21 percent of the near elderly (4.5 million persons) spent some time without health insurance. About one-fifth, (4 percent of the near elderly) were continuously uninsured during the period while the rest spent only part of the time without coverage [Jensen 1992].

The insurance problems of the near elderly differ in some fundamental ways from those of younger persons. My research has found that older women are particularly vulnerable to periods without health insurance, and within this age range account for twice as many spells of noncoverage as do men (women account for 59 percent of spells). Unlike younger cohorts, when near elderly persons lose health insurance, the coverage they lose tends to be employer coverage. Instead, most uninsured spells are ones in which individual health insurance is lost. The majority (71 percent) of spell beginnings among the near elderly are unrelated to changes in either the individual's employment or their spouse's employment (e.g., beginning retirement, reducing the hours one works, or becoming unemployed). Yet, most (54 percent) uninsured spells end when employment within the household increases. Most of the jobs acquired when employment increased, however, are not jobs that carried health insurance fringe benefits. The extra income from the employment is nonetheless often used to purchase private nongroup coverage. Among the near elderly, few spells without health insurance (only 5 percent) end by "aging into" Medicare [Jensen 1992].

Some proposed reforms to expand health insurance, such as an all-employer mandate, a "pay-or-play" employer mandate, and extending Medicaid to persons in poverty, are less effective in reaching this medically high-risk population than in reaching younger persons who are uninsured. An employer mandate, whether to provide coverage directly or to pay-or-play, would bypass most of the uninsured 55 to 64 years of age for a simple reason. Only one-third of those experiencing periods without health insurance in this age rage work full-time jobs for any part of the year. The rest are either retired, are outside the labor market altogether, or they work part-time. Since 56 percent of the uninsured in this age range are married, an extremely optimistic upper bound is that 51 percent of the near elderly uninsured might be newly covered under an all-employer mandate [Custer and Jensen 1990]. Most likely, however, fewer would be covered, because the spouses of many workers are employed themselves, and this would lower the extent of new coverage that would result. About two-thirds (61 percent) of those left uninsured by an all-employer mandate would be women.

An expansion of Medicaid to all persons at or below the federal poverty level would likely reach only one-quarter of the uninsured ages 55 to 64, because most

uninsured in this age range have a household income above this level. If Medicaid were expanded to persons within 200 percent of the poverty level, then 63 percent of the uninsured near elderly would newly gain coverage. However, this type of extension would create strong incentives among the near elderly who now purchase individual health insurance to substitute "free" Medicaid coverage for costly private coverage. Approximately one-quarter (27 percent) of the near elderly with family incomes less than 200 percent of poverty now purchase private health insurance not sponsored by an employer. If all these individuals switched to the public program it would add another 1.5 million to the older adult Medicaid rolls, representing a massive cost transfer to public programs.

EMPLOYER-SPONSORED RETIREE HEALTH INSURANCE

One out of four near elderly persons (5.5 million persons) are retired, and most of these people (3.8 million) receive retiree health insurance from a former employer. Among retirees ages 55 to 59, 71 percent have employer-sponsored post-retirement coverage and among retirees ages 60 to 64, 67 percent have such insurance. Five percent of this retiree health insurance is COBRA coverage, which is limited to 18 months beyond the date the individual retired; the rest is coverage that continues until the retiree becomes eligible for Medicare or it is coverage that continues indefinitely [Monheit and Schur 1989; Zedlewski 1993]. Post-retirement health insurance benefits are generous, with provisions roughly similar to active worker benefits. We know this because 94 percent of retirees who receive this benefit are retired from a large firm (with 1,000 or more workers), and large firms typically (79 percent of the time) offer retiree benefits which are the same as those provided to active workers [Morrisey et al. 1990].

The prevalence of retiree health insurance has grown over the last decade, and a high percentage of current workers of all ages now expect to receive retiree health insurance because their employers have promised them that benefit. Two-thirds (67 percent) of all workers in medium and large private firms and 77 percent of non-federal government employees work for employers that now provide this benefit to retirees [Jensen and Morrisey 1992].

To maintain and further stimulate the growth of employer-paid post-retirement health insurance, one policy option worth serious consideration is a tax subsidy to either employers (or employees) to provide post-retirement health benefits. One mechanism to do this would be to treat prefunded reserves for health insurance premiums in a fashion analogous to that of pension plans. Although creating such a tax subsidy would entail a revenue loss to the government, it would likely encourage more firms to provide retiree coverage, and give firms which currently promise these benefits stronger incentives to adequately prefund them.

Under some health care reform proposals the current incentives for employers to provide retiree health coverage would likely be maintained, while under others the incentives could be significantly dampened As I understand it, the President's reform package calls for sharing the burden of insurance for retirees between the government, which would pay 80 percent of the average cost of HIPC coverage, and the retirees themselves, who would pay the incremental cost of joining the plan of their choice. Employers who now provide retiree coverage would be required to pay the individual's share toward coverage. This plan will almost certainly cause most employers to end their provision of retiree benefits because workers will no longer have a strong need for employer-sponsored coverage. Eventually the government will incur the full cost of providing insurance for this population. Also, research on individuals' decisions to retire suggests that many persons will retire sooner if given access to health insurance between the time they stop working and Medicare. This would have major implications for government tax revenue. Including retirees in the HIPCs will also raise the average cost of HIPC coverage for all payers, and result in many employers paying more towards workers' coverage than they currently pay. For small firms this may be particularly burdensome.

Other proposals, such as an employer mandate to provide direct coverage, or a mandate placed on individuals, e.g. that they secure health coverage for themselves until becoming eligible for Medicare, would appear to retain employers' present interest in sponsoring retiree health plans. A mandate on individuals might actually encourage more firms to provide retiree coverage by stimulating workers' desires for it. An individual mandate would likely not reduce current retiree coverage because, as noted above, nearly all of it (94 percent) is supplied by firms with 1,000 or more workers, which would surely continue to sponsor health benefits.

LACK OF HEALTH INSURANCE AMONG FIRMS

Full-year full-time workers who are uninsured lack coverage because their employers do not sponsor group insurance plans, and these workers choose not to buy insurance on their own. We know this because full-time employees overwhelmingly (99 percent) are eligible to participate in a health insurance plan if their employer offers one (even within very small businesses), and because workers rarely ever turn down group coverage to remain uninsured—only 2 percent do so [Morrisey et al. 1993; Long and Marquis 1992]. Thus, the nature of insurance offerings among employers and the reasons why some firms decide not provide health benefits are central to understanding of the problem of the uninsured.

Employer provision of health benefits is strongly related to the size of the firm. In 1993, 44 percent of firms with fewer than 10 employees sponsored a health insurance plan, among firms with 10 to 24 employees 70 percent sponsored coverage, and among firms with 25 to 49 employees 85 percent maintained a plan [Jensen et al. 1993]. The prevalence rate for this last group approaches that of medium and large size employers. For example, among firms with 100 to 999 employees, 95 percent sponsored health insurance and among those with 1,000 or employees, 98 percent did so [Sullivan et al. 1992]. Thus, lack of coverage is predominantly a very small firm issue.

The provision of insurance by small firms has changed over time, and the trend in the prevalence of benefits to some extent reflects changes which have occurred in the overall U.S. economy. Among all firms with 1 to 49 employees, the provision of health benefits declined between 1989 and 1991—from 41 to 34 percent of small businesses, but has increased markedly since then—50 percent sponsored a health plan in 1992, and 51 percent did so in 1993 [Morrisey et al. 1993]. On one hand, this may seem inconsistent with the trend in size of the uninsured population over this period. As noted earlier, CPS data show that the number and percent of persons uninsured inched upward every year between 1989 and 1992. However, the economy changed in ways over this period that can help explain the two trends.

First, in Fall 1990 the economy slipped into recession, and unemployment increased. Much of the increase in unemployment resulted from firms downsizing, and many firms have been slow to rebuild their workforces. Firms that reduced their employees would show up as smaller sized firms in 1992 and 1993. If they previously offered health insurance and continued to do so after downsizing, then we should expect the percentage of small firms offering coverage to be higher in 1992 and 1993, as it is.

Second, it is important to understand the factors which underlie the trend in the CPS numbers, which are not ones that suggest that fewer small firms are now offering health insurance. Since 1989, spells of unemployment and total withdrawals from the labor force have become more commonplace. Between 1989 and 1992 the percentage of individuals living in households headed by someone unemployed for part of the year increased from 7 to 9 percent, and the percentage in households headed a nonworker the entire year increased from 10 to 12 percent [EBRI 1990, 1994]. Since an unemployment spell usually triggers a spell without health insurance, and since families without a working head have limited access to insurance, these changes in the labor force have contributed to the increase in the uninsured population. They are not factors, however, that would lead to fewer firms to offer coverage.

Third, since 1989 the labor force has shifted away from full-time workers, and moved more toward part-time workers who are typically ineligible for employer coverage. Between 1989 and 1992, the economy incurred a net loss of 639,000 full-lime jobs, while at the same time, it saw a net increase of 894,000 part-time jobs [BLS 1993]. This trend alone—the substitution of part-time for full-time labor in the U.S.—can account for an increase of approximately 1.5 million in the number of workers without health insurance between 1989 and 1992, and correspondingly, a substantial part of the increase in the size of the uninsured population. Yet clearly, such a substitution need not lead to firms dropping their health insurance plans for full-time workers.

Among small firms that offer coverage, the benefits provided are about as broad as large firm benefits, but they are not as deep. That is, the plans tend to cover the same categories of care as large-firm plans, but they are less generous in the amount of medical expenses they cover. Average deductibles under major medical, for example, are about 50 percent higher in small firms ($311 per individual in 1993 compared with $222 in firms with 1,000 or more workers). Lifetime maximum benefits also tend to be somewhat lower in small firms. The benefits offered by small firms have improved since 1989, and as a result, there are now fewer differences between small and large firms. In 1993, the average monthly cost of conventional

health insurance in small firms was $185 for single coverage and $428 for family coverage. For comparison, in firms with 1,000 or more employees conventional plan premiums for single and family coverage were $172 and $446, respectively. [Morrisey et al. 1993; Gabel et al. 1994].

Recently, some observers have expressed a concern that many small firms may, in fact, be unable to offer health insurance because coverage is inaccessible to them. Insurers have been accused of "red-lining" entire segments of the small group market and of cream-skimining groups they do sell to. The evidence for such practices, however, is scant. It is true that many small businesses that do not offer health insurance fear that they would have difficulty qualifying for group coverage: about half (54 percent) say that this is one of the reasons why they do not offer a plan [Morrisey et al. 1993]. Yet, when asked if this is because "one or more employees cannot qualify for insurance because of health conditions" more than three-quarters (77 percent) say no, and only 18 percent say that it is the reason. Very few small firms that do not offer health insurance believe that the type of business or industry they are in makes them ineligible for a policy (only 8 percent believe this).

The actual extent of denials of insurance coverage based on the health conditions of workers or their dependents is also modest in the small group market [Morrisey et al. 1993]. Among small firms currently offering insurance, the large majority (88 percent) indicate that all workers and their dependents are included in the plan, regardless of health conditions. Only one in ten exclude a worker or a dependent of a worker because of poor health. In addition, among firms that do not offer coverage but which previously provided it, almost none (3 percent) indicate that they stopped offering coverage because an employee or their dependent was unable to qualify, and very few (9 percent) say that their insurer refused to renew the policy. It is also true that small firms are inundated with solicitations to purchase coverage: over three-quarters indicate that they get one or more solicitations in a six month period, often more than 5 inquiries. Thus, while there are concerns about access to insurance, the reality is that most small businesses can get coverage if they want it

Small firms that choose not to provide health insurance do so for a multitude of reasons. When asked directly why they do not offer coverage, the most common answer is that premiums are too high (90 percent of businesses with 1–49 employees gave this explanation for not offering health benefits in 1993 [Morrisey et al. 1993]). It is other reasons given in tandem with this one, however, that provide insight as to why half of all small firms find it not worthwhile to sponsor a group plan.

There are three basic reasons why small firms choose to not offer health insurance. First, they fear they might have to take away coverage in the future were they to begin offering it. While many firms (56 percent) give this explanation directly, others suggested it indirectly. For example, more than three-quarters express concerns that the firm's profits are too variable, or that insurance premium increases are too uncertain to commit to the benefit.

Second, health insurance benefits are not a high priority among the firm's workers. Over half of small businesses (53 percent) note that their workers already have coverage through a spouse or parent, and the same percentage indicate that their workers prefer higher wages. Many also say that insurance is not needed to attract workers.

Third, the administrative burden and the ability to qualify for group rates are the prime concerns. For firms with 1 to 9 employees, this reason is common.

Research shows mixed findings on the issue of whether more small firms would sponsor health benefits if the price of group coverage was lower. On one hand, studies of the actual purchasing decisions of small firms made in real markets suggest that the price of a plan does play a significant role: a five percent decrease in premium would likely increase the proportion of small firms sponsoring a plan by 13 to 15 percent [Jensen and Gabel 1992; Leibowitz and Chernew 1992]. In today's market, this would translate into an increase of 7 percentage points in the percentage of small firms that voluntarily sponsor coverage, i.e., from 51 percent currently to 58 percent.

In addition, when asked directly about what price discounts would lead them to offer insurance, many small firms that currently do not offer coverage say they would offer it if only premiums were lower. A survey by the National Federation of Independent Businesses, for example, found that 42 percent of non-offerors indicated they would sponsor a plan if premiums were 20 percent lower, and 52 percent indicated they would if premiums were 50 percent lower [Hall and Kuder 1990]. More recent surveys by Louis Harris Associates, Harvard University, and myself find similar indications of strong price responsiveness among small firms [Edwards et al. 1992; Morrisey et al. 1993].

On the other hand, some studies suggest that small businesses are not very price responsive. In several insurance market demonstration projects sponsored by the Robert Wood Johnson Foundation and the state of New York, for example, researchers found that few small firms responded to incentives which reduced a firm's cost of offering a plan. Even when offered a very large premium discount (e.g., on the order of 50 percent), most still declined purchase Thorpe et al. 1992; Helms et al. 1992]. The researchers acknowledge, however, that the marketing of these demonstration projects, 'and restrictions on who was eligible to participate in some of the programs may have dampened their potential effects.

On balance, it is unclear whether subsidizing the price of insurance for small businesses would significantly encourage more firms to voluntarily sponsor coverage. A very large subsidy (e.g., on the order of 50 percent) would certainly be needed to induce most small firms to voluntarily offer insurance, but even under this scenario, all studies to date suggest that at least 25 percent of firms which do not now offer insurance would prefer to still decline coverage.

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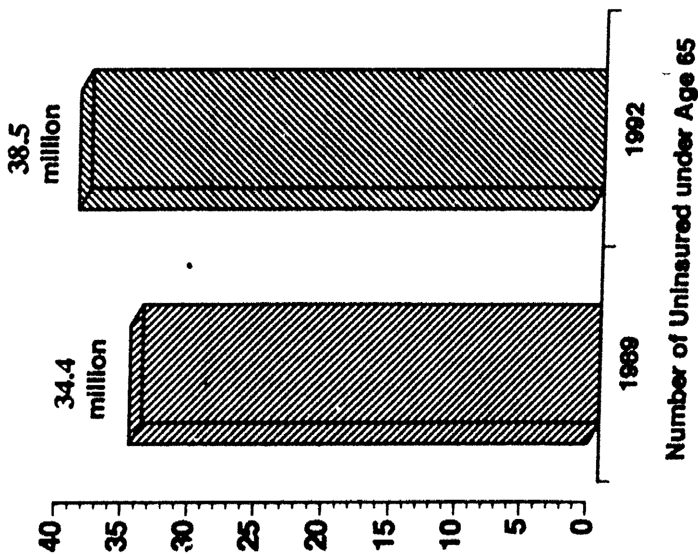
Some Reasons Why 4.1 Million Nonelderly People are Uninsured in 1992 as compared to 1989

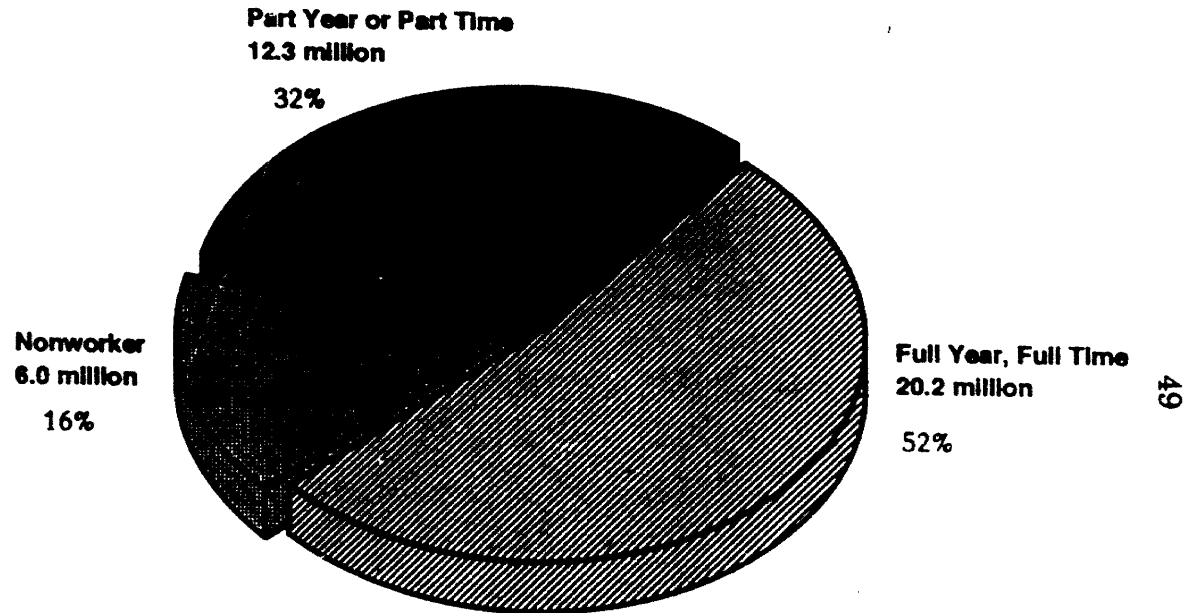
Factors Contributing to the Increase:

1.0 mil.	More Persons are in Families Headed by a Non-worker
1.9 mil.	More Persons are in Families Headed by Someone Unemployed For Part of the Year
0.45 mil.	Fewer Full-time Jobs in the U.S.
0.75 mil.	More Part-time Jobs in the U.S.
4.1 mil.	



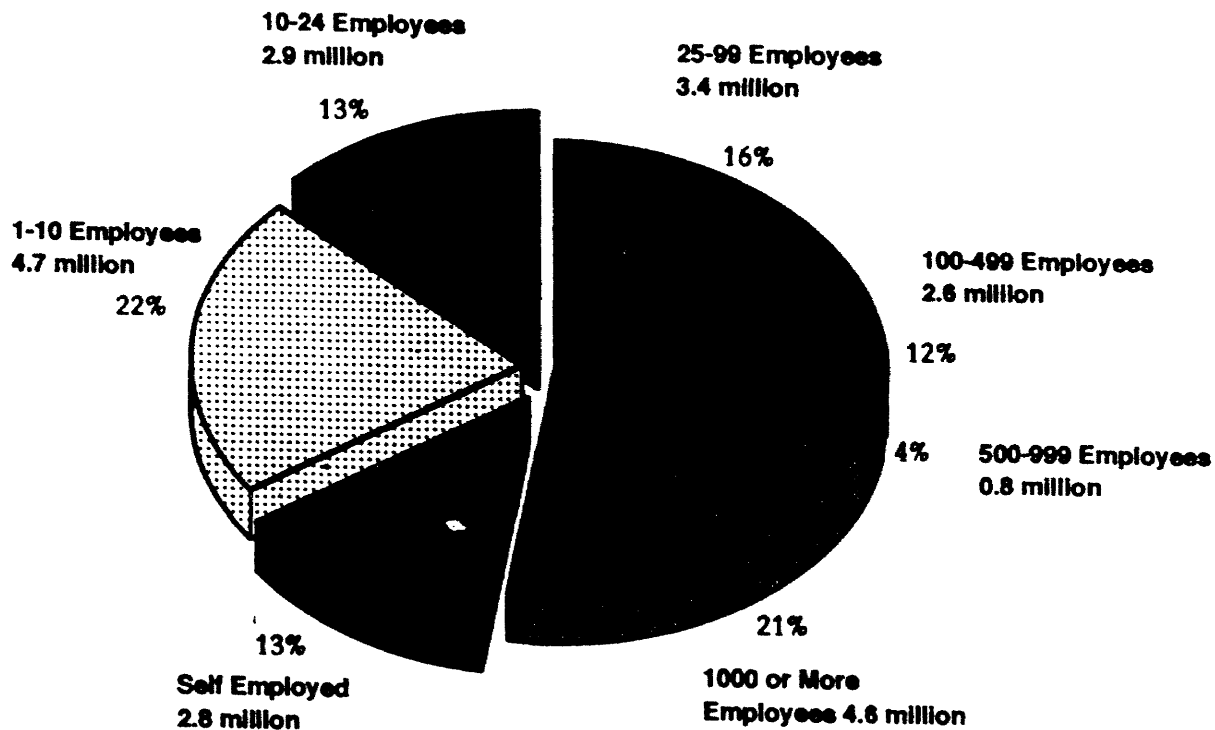
Source: Tabulations of the Current Population Survey, 1989 and 1992

Nonelderly Population without Health Insurance, by Work Status of Family Head, 1992



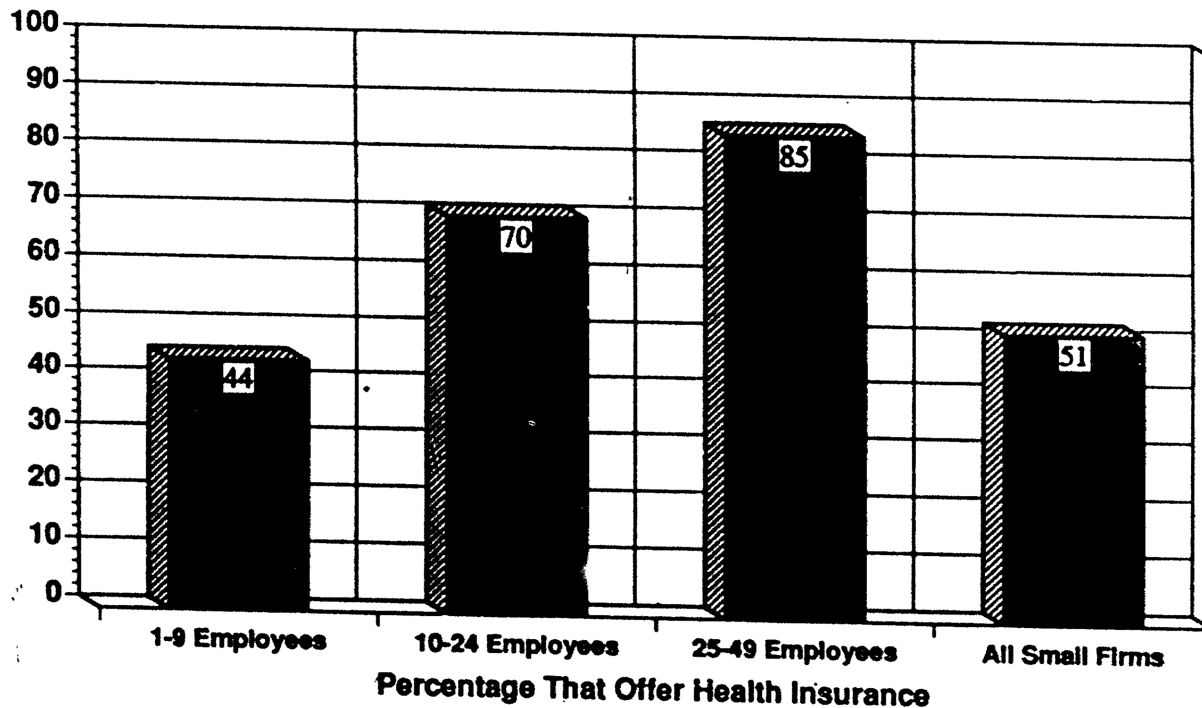
Source: Employee Benefit Research Institute Analysis of the March 1993 CPS.
38.5 Uninsured Under Age 65

Workers Aged 18-64 without Health Insurance, by Firm Size, 1992



Source: Employee Benefit Research Institute Analysis of the March 1993 CPS.
21.9 Million Uninsured Workers

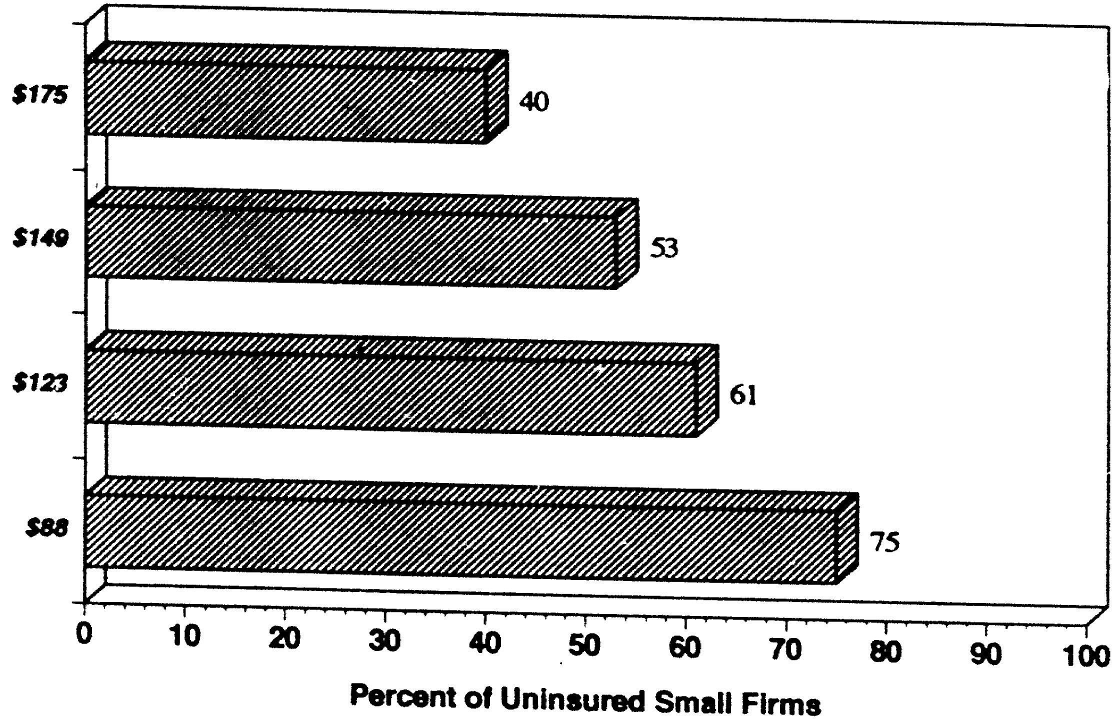
The Percentage of Small Firms That Offer Health Insurance by Size of Firm, 1993



Source: Wayne State University/KPMG Peat Marwick
Survey of 750 Small Firms, Spring 1993

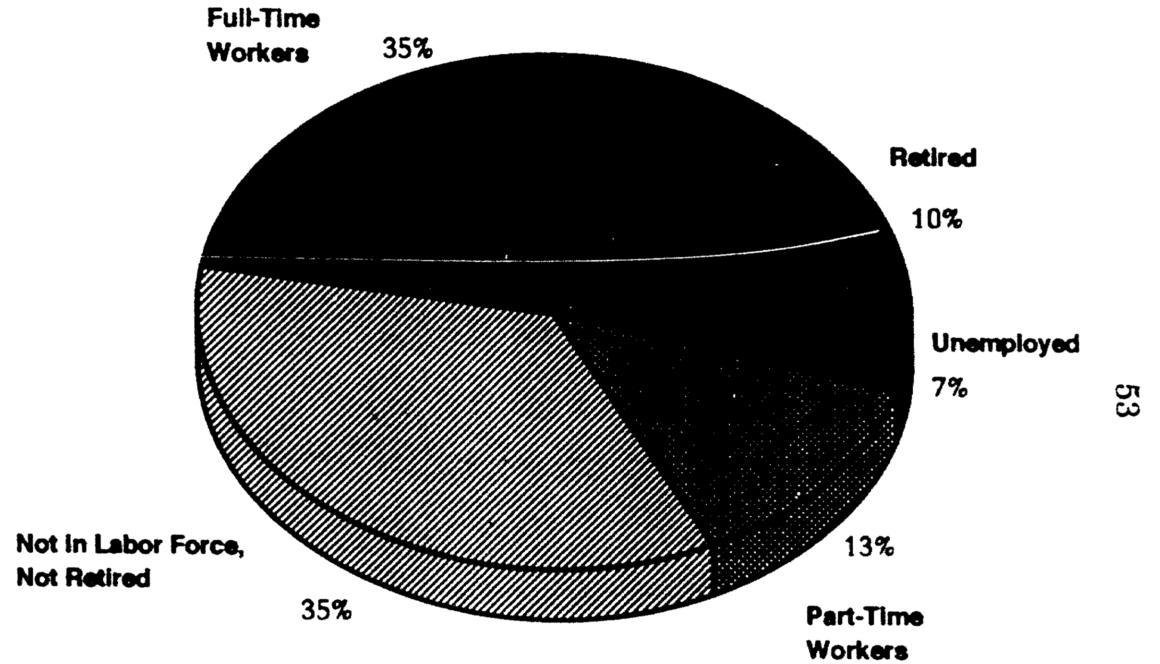
Percentage of Uninsured Small Firms Willing to Pay for Conventional Coverage at Various Hypothetical Prices

Dollars/Month



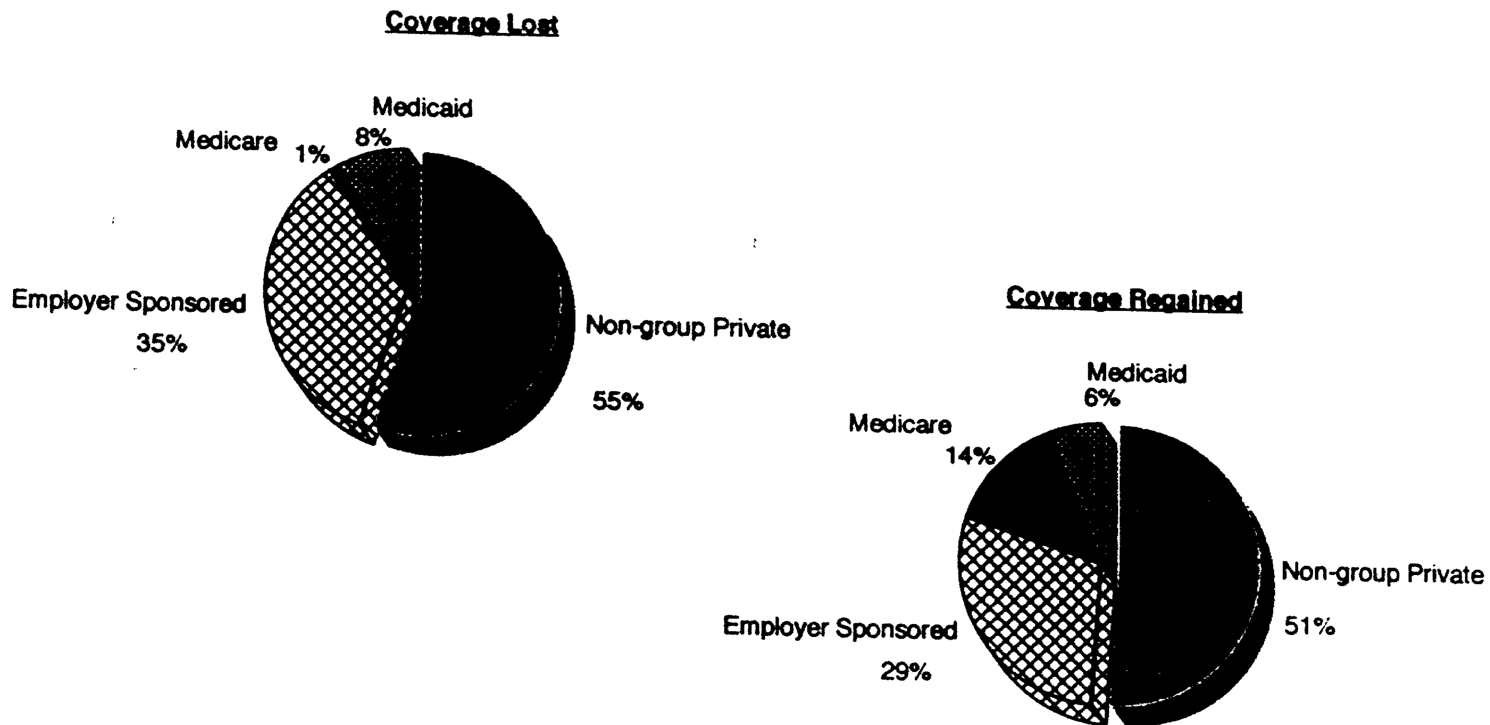
Source: Wayne Stat[illegible] Univ[illegible]rsity/KPMG [illegible]

Work Status of Uninsured Persons Ages 55 to 64



Source: Jensen (1992). Tabulations from the Survey of Income and Program Participation.

Type of Insurance Lost and Regained Among Persons Ages 55 to 64



Source: Jensen (1992). Tabulations from the Survey of Income and Program Participation

PREPARED STATEMENT OF ANNE MARIE O'KEEFE

Good morning. It is a great honor to speak to you today. The health system reform you are contemplating in this series of hearings could be the greatest accomplishment of this Congress.

I would like to begin by introducing the Washington Business Group on Health to you and explaining why we have existed over the last 20 years. I would like to then offer you the wisdom of what we have learned during those same two decades.

Let me say first that WBGH, like all of you, strongly endorses the goal of universal health care coverage. Universal coverage is right from a philosophical and an economic point of view. This is why no one is against it. But we do have honest differences on how to achieve it.

With all good intentions, the Clinton Administration has proposed to achieve universal coverage by eliminating employers as aggressive purchasers of care, and replacing them with huge public alliances. Under this scheme, employers would continue to pay the bill for health care coverage, but they would have no control over the quality or cost of care. Rather, employees in the regional alliance would be purchasing coverage as individuals. This design would remove the positive forces of competitive purchasing from the health care marketplace, and wipe out many of the important advances that employers have achieved. The Congressional Budget Office reached essentially the same conclusion in their analysis of the Clinton plan.

We respectfully suggest that to succeed in providing high quality, affordable care to all, reform should preserve and build on what is good about our health care system.

THE WASHINGTON BUSINESS GROUP ON HEALTH

The Washington Business Group on Health (WBGH) is the nation's only organization representing large employers solely on issues related to health care. It was created 20 years ago to address the growing imbalance between the rising prices that employers were paying for health care, and their lack of control over what they were buying.

Today, WBGH's 200 members, mostly Fortune 500 companies, include the nation's most knowledgeable, progressive and successful managers of the health care they provide for their more than 30 million employees. We often describe the Business Group as representing the evolution of large employers from passive payers to active purchasers of health care.

Our membership spans the gamut of big business in America. In fact, at Chairman Rostenkowski's December 15th hearing on the effects of health care reform on the national economy and jobs, two of our member companies—Ford Motor and PepsiCo—testified on the same panel, but highlighted the diversity in the business community's reactions to the Clinton plan.

This diversity is a source of strength for WBGH. It means that our member companies suppress their differences to concentrate on the goals that we share. These goals include: reforming the health care delivery system; maintaining an active role for employers in health care purchasing; and small market insurance reform. Achieving these goals will ensure vigorous competition among high quality, affordable health plans.

ORGANIZED SYSTEMS OF CARE

For years we have heard a common complaint: Health care in American is more expensive than anywhere else in the world. Yet, by such straightforward measures as infant mortality and longevity, we rank nowhere near the top in terms of quality of care or quality of life. Why is there such a tremendous mismatch between our health care investment and return?

The reason is that until recently, our health care system has been disorganized, uncoordinated and unmanaged. Services were provided according to the diverse demands of individual providers and consumers, with perverse incentives introduced by third-party payers. But they were not provided in a coordinated manner based on best outcome for the patient and best value for the dollar.

The member companies of WBGH discovered this flaw in the health marketplace, and set about to fix it. What employers discovered is that they could not solve the discrete problems in health care—the uncontrollable costs, the variable and often unknowable quality, and the unequal access—until and unless they fixed the way that health care services are delivered. This is why WBGH's signature button reads: *It's the delivery system, stupid.*

The successes that our member companies enjoyed, as well as what they learned along the way, comprise the most exciting developments in health care in recent his-

tory. I say this not just to brag, but to remind the Members of this Committee that health reform in this country did not begin with the Clinton Administration, or the presidential campaign, or even with Senator Harris Wofford's campaign in Pennsylvania. Health reform in America began, and is going on now at an accelerating pace, within the business community.

Health reform began because employers with *their* money and *their* workers' productivity at stake started using *their* market clout to get better quality health care at a lower cost.

The secret to our employers' success is what we call *organized systems of care* or OSCs.

Our use of the term OSC is comparable to what we understood the White House to mean by their early use of the term "accountable health plans. " (Unfortunately, the word "accountable" seems to have been dropped along the way.) The concept means that unified and accountable health care delivery systems serve all Americans and replace the fragmented, inefficient, costly and unmanaged fee-for-service approach that many health consumers still face today.

Organized systems of care integrate financial risk with responsibility for outcome. These OSCs provide a full continuum of care, and are accountable to patients and purchasers for its cost and quality.

Largely because of the pressures exerted by large employers as caring, invested and informed group purchasers, providers are organizing into systems that can deliver the highest quality care at the best price. In OSCs, services are integrated and care is managed for optimal outcome. Waste and redundancy are reduced because procedures are performed not for their profit but for their efficacy. Consumers are educated about their role in their own health, and empowered to take control over the quality of their lives. Iatrogenic or physician-induced problems are drastically reduced. In fact, the entire focus of care shifts from sickness to health.

THE QUALITY OF CARE

To purchase good care, large employers understood that they had to have good information. The Committee should appreciate that when employers first started asking the questions that would allow them to evaluate, monitor and improve the quality of health care, there were no answers. In the beginning, not even the best organized health systems could tell purchasers what their Cesarean-section rates were (let alone the rates of vaginal births after C-sections), or the hospitalization rates for treating asthma, or the relapse rates after treatment for substance abuse.

To meet the need for this information, employers began an effort that resulted in the recent publication of *HEDIS.2* (the Health Plan Employer Data and Information Set). As explained in the document, *HEDIS.2* helps purchasers to measure the value of the services they are buying and to implement programs that assure continuous quality improvement.

Throughout this process, one of the most exciting discoveries was that when purchasers concentrate on improving *quality,* the cost of care comes down. Actually, this won't surprise any Members of the Committee who have availed themselves of the highest quality care in this country, which often comes at the most reasonable prices, from centers of excellence such as the Mayo Clinic.

There are several reasons for the often inverse relationship between cost and quality. In medicine, as in other professions, skill develops over time and with experience. It is not surprising that a physician who has performed hundreds of coronary bypass procedures is better at it than is a beginner. Expertise also develops with the increasing experience of surgery support teams and other ancillary personnel. As is true in other sectors of the economy, high volume reduces per capita cost. In addition, the symptoms treated by high-tech, highly invasive and high-cost procedures are frequently caused by mental and emotional problems. These symptoms often disappear with appropriate, low-cost mental health care.

In rural and other underserved areas, organized systems of care, relying on good information technology and advanced techniques such as telemedicine, provide remote patients and practitioners access to the full range of specialized personnel, diagnostic equipment and treatments.

Finally, OSCs provide the best quality care because each consumer has a physician who coordinates and manages services to achieve the optimal outcome. This primary care doctor serves as the patient's counselor and advocate. She makes referrals to the best and most appropriate specialists when warranted. She helps to insure that children receive their full schedule of vaccinations, that men are screened for prostate cancer, and that women get regular pap smears and mammograms. With access to the patient's full integrated medical record, she protects against redundancy, conflicting treatments, and multiple medications that, when combined,

could prove toxic. In short, this persons functions as the family physician in the best, old fashioned sense of the term.

THE ROLE OF EMPLOYERS

Given all that employers have learned, and all that they have accomplished, it would be a terrible irony if reform excluded them from the purchase and delivery of health care. Unfortunately, the Clinton proposal offers no recognition of health care as an employee benefit issue. Instead, it seems to perceive employers as merely the payers for care.

Under the current Clinton proposal, the costs and other burdens of creating a corporate alliance are too high, and the returns for those who do are too low. We have found relatively few corporations, even among those large enough to do so, that would create their own corporate alliance.

Setting the threshold at 5 employees for even the opportunity to choose not to be in the regional alliance defies the concept of "managed competition." It would leave only 18 percent of the population eligible for corporate alliances. The Washington Business Group on Health has long endorsed a threshold of 100, which is also the recommendation of the Jackson Hole Group. This is why we were delighted to hear Treasury Secretary Bentsen say recently that the Administration is flexible on this point.

We must emphasize that simply charging employers a percentage of their payrolls to finance health care coverage sold to individuals in large regional alliances would not keep these employers engaged in improving the quality and reducing the cost of care, nor in the aggressive health promotion programs that have sprung up at worksites across the country. Giving employers seats on the boards of directors of these alliances is simply not a substitute. We very much want the continued active involvement of these skilled, experienced and successful evaluators, negotiators and purchasers of care. This should be a central goal of health care reform.

The role that employers as purchasers now play cannot be supplanted by the bureaucracy detailed in the Administration's proposal. The very size and cost of this bureaucracy is incongruous with Vice President Gore's proposal to downsize government. Throwing the 41 percent of persons who work for small (1–99), medium (100–999) and large-but-not-really-large (1,000–4,999) businesses into these public pools would destroy much of the good that has been accomplished, and waste the value that employers as purchasers add to the system. It would also eliminate many of the most successful local purchasing coalitions, such as the New York Business Group on Health. Instead, all of these people, and all of those in the largest (5,000+) companies that did not form corporate alliances, would be evaluating, negotiating and purchasing their plans as *individuals*. With none of their own money at stake, and no investment in worker productivity, the alliances could never do what employers now do. This opinion is shared by many businesses and individuals throughout the country.

COVERING THE UNINSURED

We need health care reform. But we must take this opportunity to do it right. It would be a terrible failure if, in the rush to pass some kind of reform, we rearranged the financing for the current system, destroyed the incentives for continued active involvement by employers, and did not fix the delivery system.

The Washington Business Group on Health does not think we need the wrenching changes proposed by the Clinton Administration. In their analysis of the financial impact of the Clinton proposal, Lewin-VHI concluded that "Overall, about 53 percent of employers will see a change in spending—either an increase or a decrease—of $1,000 or more per employee."

Toward the goals that we all share, WBGH strongly recommends that we begin health care reform by preserving and building on the best parts of our current system, and reforming the small markets to provide real universal access to quality care. Some say glibly that we have universal access now, while we still have 37 million uninsured persons. But we do not have universal access as long as small groups with even one high risk person are charged unaffordable premiums or forced to exclude those employees from health coverage who need it most. We do not have universal access as long as insurers can exclude coverage for preexisting conditions, or refuse to provide coverage altogether based on medical underwriting. We do *not* have universal access as long as even healthy and fully insured Americans fear that loss of coverage is only one job change or one serious illness away.

Health reform should redesign the purchaser market to pool individuals and small employers in both the private and public sectors into coalitions that are large enough to insure access to coverage and achieve economies of scale. We recommend

that these purchasing pools include persons who buy coverage as individuals or single families, and those who work for establishments with 100 or fewer employees. (One hundred is sufficient to spread risk and achieve economies of scale.) These coalitions would serve to organize very small groups into pools large enough to force increased competition among health plans.

To insure affordability, WBGH supports subsidizing low-income individuals up to 200 percent of poverty. We also strongly support a decoupling of health care coverage from welfare. This would allow people to work and be assured of health care services for themselves and their children. Most important, Medicaid beneficiaries and other vulnerable populations must have access to well managed, high quality care in OSCs that have incentives to provide primary and preventive care in appropriate settings, not emergency rooms.

The individuals who purchase through these pools must have access to organized systems of care or accountable health plans. Such plans should offer comprehensive, federally-defined coverage. These plans should be prohibited from denying, or prohibitively pricing, coverage for selected individuals or for preexisting conditions. They must report and make available the full range of information that is necessary for consumers to be wise purchasers. In effect, the health plans will be forced to compete on the cost and quality of care, rather than on benefit design and risk avoidance.

Toward our common goal of insuring all Americans access to the highest quality health care in the world, WBGH respectfully makes several other specific recommendations.

Inclusion of Medicare: WBGH strongly believes that health care reform should benefit *all* people. Older Americans, who are higher utilizers, are particularly vulnerable to the worst aspects of fee-for-service care, including its high cost, low efficiency, shortage of good information, lack of coordination and absence of management. Unsurprisingly, older Americans suffer the most from the results of unmanaged care. An estimated 25 percent of hip replacements are in persons in this population who have fallen because they were overmedicated.

WBGH strongly recommends that health reform be structured to extend the benefits of organized systems of care to those who could benefit most from them, including Medicare and Medicaid beneficiaries. Studies of Medicare beneficiaries who voluntarily joined HMOs have shown that overall, consumer satisfaction is high. In a recent study done by Mathematical Policy Research, Inc., 93 percent of Medicare HMO enrollees reported that they would recommend their HMO to a friend or relative.

We think it is particularly ill conceived to add a prescription drug benefit to Medicare while specifically excluding the program from reform, as the Clinton proposal does. Coverage of prescription drugs has been one of the major inducements to bringing older Americans into managed care, and this approach would take away this incentive.

Antitrust Reform: WBGH endorses reform of antitrust law to protect and encourage the development of vertically integrated health networks. Our vision of organized systems of care encompasses the close cooperation of a broad range of providers, the provision of comprehensive services, the availability of all information useful to the consumer, and administrative ease. The vertical integration of many different facilities and providers is crucial to achieve this ambitious vision.

WBGH also supports the redesign and enforcement of antitrust law to ensure competitiveness in the health care marketplace. This may require repeal of the McCarran-Ferguson Act, the 1945 law through which the federal government ceded control over the insurance industry to the states, including an effective exemption for the industry from federal antitrust law. Bringing insurance companies under fair competition laws would bar anticompetitive insurance practices while furthering the goal of health system reform: the efficient delivery of affordable, accessible, high-quality health care.

Enterprise Medical Liability: WBGH strongly believes that the current medical liability system is in need of fundamental reform. The current system: (1) does not effectively deter negligent medical care; (2) reduces access to needed services while increasing utilization of costly, inappropriate care that can actually threaten a patient's health; and (3) resolves claims in an inefficient and inequitable manner.

WBGH supports the inclusion of enterprise liability in overall tort reform to improve the medical liability system in the context of organized systems of care. Other elements of = tort reform should include caps on noneconomic damage awards, the use of alternative dispute resolution mechanisms, and the increased use of practice parameters. Together, these measures would provide greater incentive for the OSC or accountable health plan to monitor and improve the quality of care, would lead

to a more efficient and equitable compensation system for injuries due to malpractice, and would decrease the incidence of negligent care.

Support for Information Technology: "High technology" often gets criticized as a cost driver in health care. And, in fact, the most complicated, invasive and expensive treatment is often not the best care. Unfortunately, however, the use of information technology is in its infancy in health care.

Good health care, including integrated medical records and reliable determinations of cost, quality and outcomes, requires the use of information technology. Numerous demonstrations bear witness to the utility of information technology for: measuring health plan performance; assisting patients in making informed decisions about care options; coordinating care across treatment sites; and enhancing service delivery in rural and urban underserved areas. However, there are few incentives to integrate information technology into health care delivery. Consumers, group purchasers and policymakers are generally unaware of the contributions to access, cost and quality that information technology could make, and they have been slow to advocate its development and use.

Health care reform provides an excellent opportunity to integrate information technology into emerging health care delivery systems. WBGH hopes that whatever reform is enacted will address the current barriers to optimal use of information technology, including provider reluctance, the lack of technology standards and the absence of reimbursement mechanisms.

Preservation of ERISA Preemption: Multistate employers must be able to preserve and continue their successes in health reform. We cannot return to the "bad old days," when large employers who wanted to provide health care coverage for their workers had to contend with 50 different sets of rules and 50 different benefit plans. If each state is allowed to impose its own system on employers who have workers in every jurisdiction, then those employers will simply stop providing coverage.

Comprehensive Continuum of Care: WBGH members have learned that to be high quality and low cost, health care must be comprehensive. WBGH supports comprehensive coverage defined by a National Health Board as we move toward providing treatment based on determinations of medical necessity, efficacy, severity of illness, and level of functioning. Those individuals who need intensive care should be able to get it, while the movement of individuals to less institutionalized settings and less intensive levels of care should be encouraged. OSCs or accountable health plans must offer a full continuum of services, including preventive, primary, acute, rehabilitative and chroni· care.

As a nation, the only way we will be able to afford comprehensive health care for everyone is to encourage prevention and early intervention. More than half of the illness resulting in early death and disability can be prevented or effectively managed. We can encourage preventive practice through educational efforts, financial incentives to seek early treatment, and good communication between primary and specialty care providers. This can best be done in a system consistent with managed competition where health plans are held accountable for the cost and outcomes of care.

PREPARED STATEMENT OF DIANE ROWLAND

Thank you Mr. Chairman and members of the Committee for this opportunity to testify on the uninsured and their health care needs. I am Diane Rowland, Senior Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid. I am also an Associate Professor of Health Policy and Management in the School of Hygiene and Public Health of the Johns Hopkins University.

I am pleased to be here to share the results of our analysis of the uninsured in America prepared for the Foundation's health reform project. This analysis is part of the national education campaign that the Foundation has co-sponsored with the League of Women Voters Education Fund to provide the American public with facts on who is uninsured and the impact of lack of insurance. My testimony today provides an overview of the size and characteristics of the uninsured population and the implications of lack of insurance for access to care and health status.

HOW MANY AMERICANS ARE UNINSURED?

Lack of health insurance coverage is a problem for millions of Americans and the number of uninsured Americans grows each year. In 1988, 32.6 million Americans were uninsured because they were without either public or private health insurance

[Figure 1). By 1992, that number had grown to 37.1 million people, representing 17 percent of the non-elderly population [Figure 2).

Almost all Americans without insurance are under age 65 because the Medicare program provides health insurance coverage to virtually all elderly and most severely disabled Americans. Most non-elderly Americans have private health insurance coverage obtained through their employer or individually purchased. In addition, Medicaid provides insurance to those on welfare and some related low-income groups, covering 12 percent of the non-elderly population. The 37 million uninsured Americans fall through the cracks in the employment-based health insurance system and do not meet the income and categorical requirements for Medicaid's welfare based assistance.

The 37.1 million statistic provides a snapshot of the number of uninsured people on any given day. It does not, however, capture the changes in insurance status that occur over the course of a year in which some people gain or lose coverage for part of the year. In 1993, 51.3 million people—one in five Americans—were uninsured for some period of time during the year (Figure 3). Of those uninsured during the year, only 22 percent reported their gap in insurance coverage to have lasted less than four months. Most were uninsured for a considerable period and over one third (35 percent) or 18 million people were without health insurance for the entire year or longer.

WHO ARE THE UNINSURED?

Lack of health insurance is not a problem limited to a small group of Americans. It touches one in five Americans each year across age, income, and social classes. The profile of the uninsured is a profile of working Americans and their families. More than 8 in 10 uninsured Americans are workers or dependents of workers [Figure 4). They do not receive health insurance coverage through their jobs. Over half (52 percent) of the uninsured are in families headed by a full-time worker who has been employed for the full year. Nearly a third of the uninsured (32 percent) are in families headed by a part-time worker or a full-time worker who was not employed for the full year. Only 16 percent of the uninsured are in families without an attachment to the workforce.

The fact that 84 percent of uninsured Americans come from working families is a product of how health insurance is provided in the workplace. Individuals who work for larger firms are more likely to be offered coverage through their employers. Most large firms are able to offer their employees group health insurance coverage whereas smaller firms have less ability to negotiate favorable group rates. The self-employed and employees of firms with less than 100 workers make up over half (53 percent) of the uninsured population [Figure 5). Over a quarter (26 percent) of the uninsured are from families headed by an employee of a firm with fewer than 25 employees.

Because most uninsured Americans are in families with workers, most are not poor (Figure 6). Seven in ten uninsured Americans (72 percent) are from families with incomes above the federal poverty level ($11,570 for a family of three in 1992). Most uninsured Americans are middle-class working families. Although only 29 percent of the uninsured have incomes below poverty, 59 percent have low and moderate incomes between $11 and $45,000 per year for a family of three.

Again, reflecting the dominance of working families in the uninsured population, 8 in 10 uninsured Americans are adults between age 25 and 64 or children [Figure 7). Only 19 percent of the uninsured population falls within the 18 to 24 year old age group, the age group most likely to be uninsured. Twenty-two percent of the uninsured are children.

Every state and every region of the United States has an uninsured population, but in some areas a higher proportion of the population is uncovered. The percent of the population without insurance ranges from 9 percent in Iowa and Wisconsin to 28 percent in New Mexico. This variation reflects differences among states in the nature of employment, with the South and West having a higher percentage of workers in small firms. It also reflects differences in the scope of coverage of the poor by Medicaid in the different states. These employment and coverage differences make the problem of large numbers of people without insurance more significant in the South and the West. Forty-two percent of the uninsured live in the South and 24 percent live in the West (Figure 8). Thus, any approaches to address coverage for the uninsured can be expected to have notable regional effects.

WHY ARE PEOPLE WITHOUT INSURANCE?

Most Americans under age 65 receive their health insurance coverage through their employer. Employers negotiate with insurance companies for coverage on be-

half of their employees. Most large employers qualify for group insurance coverage, but many small employers have too few employees to obtain the more favorably priced group policies. Others elect not to add the cost of health insurance for their employees to business operating costs and do not offer coverage. Employees of unionized and manufacturing firms are most likely to be covered while temporary and part-time workers are most often not covered.

Small firms are less likely to offer coverage to their employees than larger firms. Less than a third of firms with fewer than 25 workers offer health benefits in contrast to over 95 percent of firms with 100 or more workers (Figure 9). Over a quarter of the uninsured (26 percent) are employees or dependents of employees in firms with less than 25 workers.

If insurance is not offered through the workplace, individuals can still purchase private insurance coverage on their own. However, such policies are more expensive than employer-sponsored group coverage and the full premium must be paid by the individual. Most individuals receiving coverage through their employers also have an employer contribution which covers some of the premium cost for the policy. The premium cost of individual non-group health insurance policies varies widely. As an example, policies offered in the individual market in New York City for family coverage range from $6,000 per year for Empire Blue Cross to $11,000 per year with National Casualty (Figure 10). In addition individually-purchased policies often have higher deductible and coinsurance levels and more limited benefit packages than group coverage obtained through an employer. Most individual policies also exclude coverage of pre-existing health conditions.

Thus, it is not surprising that when the uninsured are asked the primary reason why they do not have insurance, 6 in 10 uninsured adults (59 percent) say they cannot afford coverage (Figure 11). Another 22 percent of uninsured adults cite loss of a job and unemployment or lack of health benefits on the job as the primary reason they are uninsured. Three percent report they cannot obtain insurance because of ill health or prior illness. Only 7 percent of uninsured adults report they are uninsured by choice or because they do not believe in insurance. For most uninsured Americans, lack of insurance is an economic, not a personal, choice.

WHAT DIFFERENCE DOES INSURANCE MAKE?

Those without insurance have more difficulty accessing the health care system and as a result use less care. They are less likely to visit doctors, especially for primary and preventive care. National survey data show that half of the uninsured did not see a physician in the past year compared to a quarter of the insured population (Figure 12). One-third (36 percent) of the uninsured report they have no usual source of care compared to 17 percent of the privately insured population and 12 percent of the Medicaid population. Having a usual source of care is generally identified with better coordination of illness episodes and greater likelihood for provision of preventive care. Lack of a usual care site could result in more fragmented care delivery for uninsured Americans.

Studies have consistently found lower utilization levels for physician care for those without insurance in comparison to the insured population. The utilization differences occur because the uninsured are less likely to seek care, especially for early and preventive care, than their insured counterparts. Seventy-one percent of the uninsured compared to twenty-one percent of the privately insured population reported that they had postponed seeking care which they felt they needed over the past year because they could not afford it (Figure 13). More striking, 34 percent of the uninsured compared to 7 percent of the privately insured reported going without needed care in the prior year because of financial reasons.

When the uninsured finally see a doctor, their health problems are likely to be worse and more difficult to treat. Being uninsured results in higher hospitalization rates for health problems which generally do not require hospital care. The uninsured are twice as likely as those with private insurance to be hospitalized for diabetes, hypertension, and immunizable conditions, all health problems which are amenable to treatment and management in a doctor's office (Figure 14). In contrast, hospitalization rates for congestive heart failure and ruptured appendix, both emergency admissions without a strong relationship to ambulatory care, are comparable for uninsured and privately insured people.

The research on differences in care patterns for uninsured versus insured individuals increasingly reveals that the uninsured not only have reduced access to care, but also are more likely to incur adverse health outcomes (Figure 15). A study of hospitalized patients found that uninsured patients were up to three times more likely to die in the hospital than privately insured patients and were less likely to

receive procedures subject to discretion, including total hip replacement and coronary bypass surgery.

One of the consequences of lack of insurance is that individuals without insurance often seek care later, at a more advanced stage of disease, and have higher mortality rates than the insured population. The risk of death for uninsured people was 25 percent higher than that of the privately insured population in a recently published study of the relationship between insurance status and survival rates from 1971 to 1987.

The differences in health outcomes by insurance status are particularly striking in the case of women with breast cancer. Early diagnosis and treatment of breast cancer is important to successful management of the disease. However, women without insurance are more likely to be diagnosed at a more advanced stage of the disease than privately insured women. During the four to seven years following their initial diagnosis of breast cancer, uninsured women were 49 percent more likely to die than privately insured women.

WHAT ARE THE CONSEQUENCES OF AN UNINSURED POPULATION?

Health insurance matters to individuals. It affects job decisions, access to care, and people's health. But lack of insurance and gaps in coverage affect more than just those without insurance. There is also a societal cost. When an uninsured person goes to a public hospital or clinic, an emergency room, or a private physician for care and cannot pay the full cost, the bill is passed on to those who do pay. This practice is referred to as "cost-shifting." Health care providers charge insured patients more to cover those who cannot pay and health insurers raise their premiums to cover the cost of care to the uninsured.

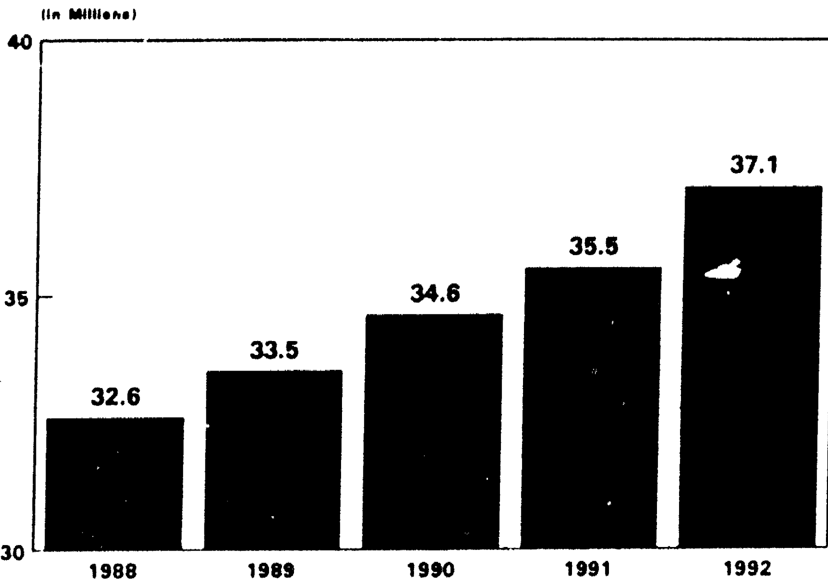
Cost shifting also occurs through the tax system. Each year the federal government pays billions in subsidies to hospitals to cover treatment for the uninsured. Increased local taxes cover the cost of public hospitals and clinics. When people who do not have insurance delay treatment because they cannot afford it, they may end up requiring more expensive emergency care. This translates to higher costs for everyone.

CONCLUSION

As the nation debates health care reform and the Congress considers the President's proposal and alternative plans, many choices will be made in determining the future shape of our nation's health care system. Much of the debate will focus on how to provide and pay for health insurance for the 37 million uninsured Americans and the millions more who are only a job change or illness away from losing coverage.

I hope that this summary of who is uninsured, why they are uninsured, and the consequences to individuals and society of having one in five Americans uninsured for some period of time during the year will help inform your debate. Thank you.

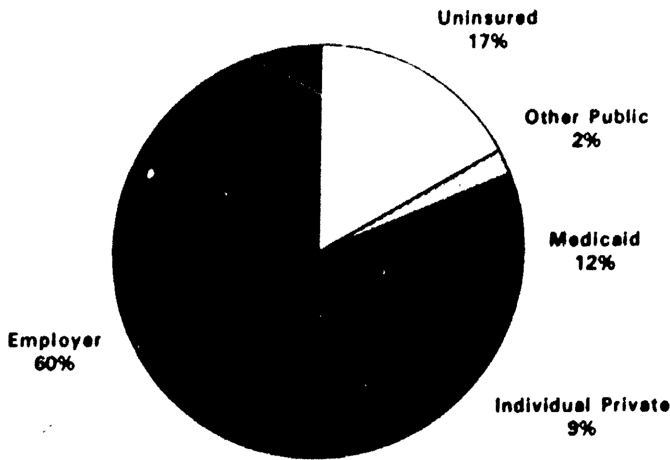
Figure 1: Number of Individuals under Age 65 without Health Insurance, 1988-1992



Source: The Urban Institute analysis of 1993 CPS.

Kaiser Health Reform Project

Figure 2: Distribution of the Population under Age 65, by Insurance Coverage, 1992

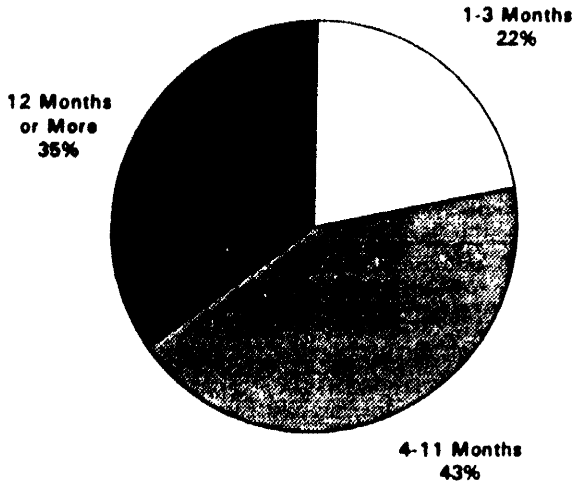


Total = 223.3 Million

Source: The Urban Institute analysis of 1993 CPS.

Kaiser Health Reform Project

Figure 3: Distribution of Uninsured Population under Age 65, by Number of Months in a Year without Insurance, 1993

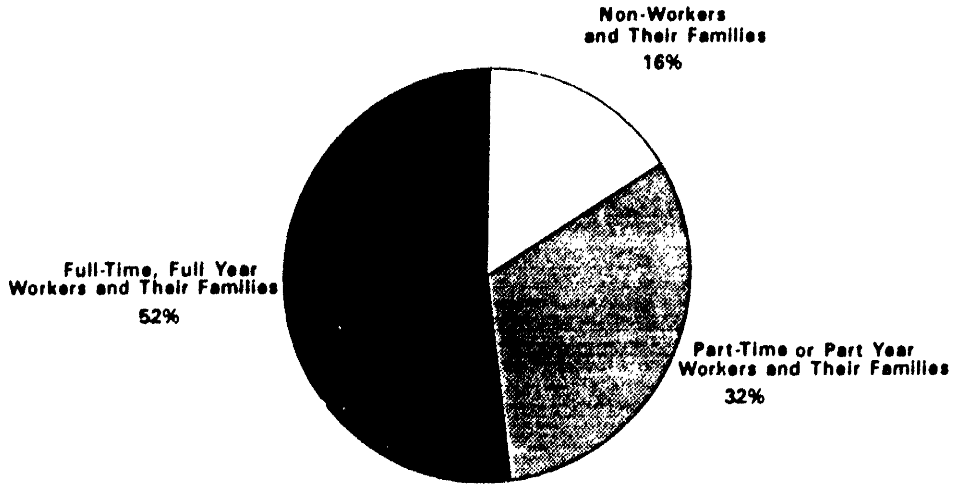


Total = 51.3 Million

Source: Lewin/VHI analysis of 1990 SIPP and Census Bureau data.

Kaiser Health Reform Project

Figure 4: Distribution of the Uninsured Population under Age 65, by Work Status of Family Head, 1992

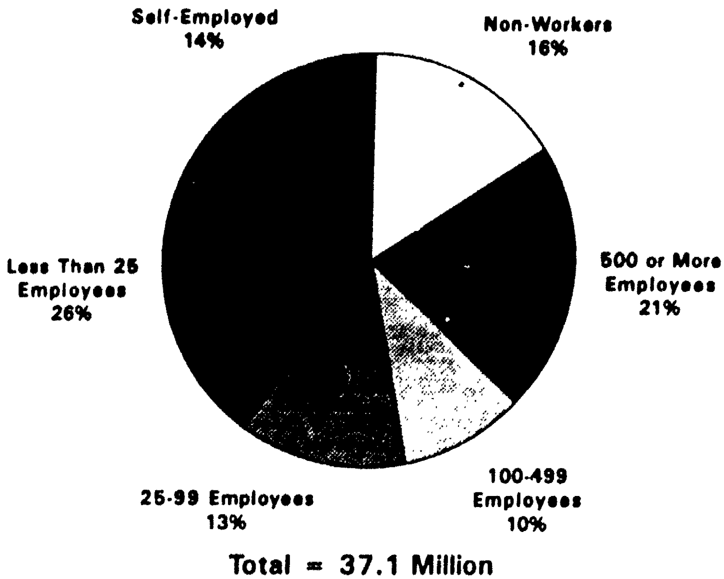


Total = 37.1 Million

Source: The Urban Institute analysis of 1993 CPS.

Kaiser Health Reform Project

Figure 5: Distribution of the Uninsured Population under Age 65, by Size of Family Head's Employer, 1992

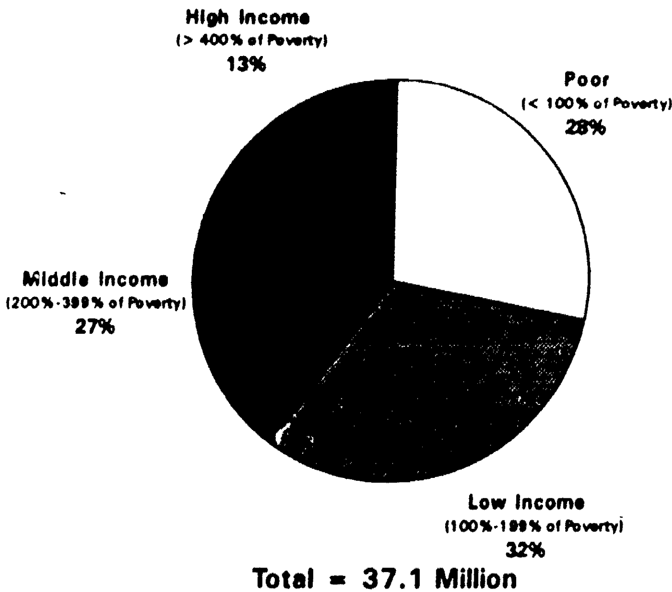


Total = 37.1 Million

Source: The Urban Institute analysis of 1993 CPS.

Kaiser Health Reform Project

Figure 6: Distribution of the Uninsured Population under Age 65, by Family Income as a Percentage of Poverty, 1992

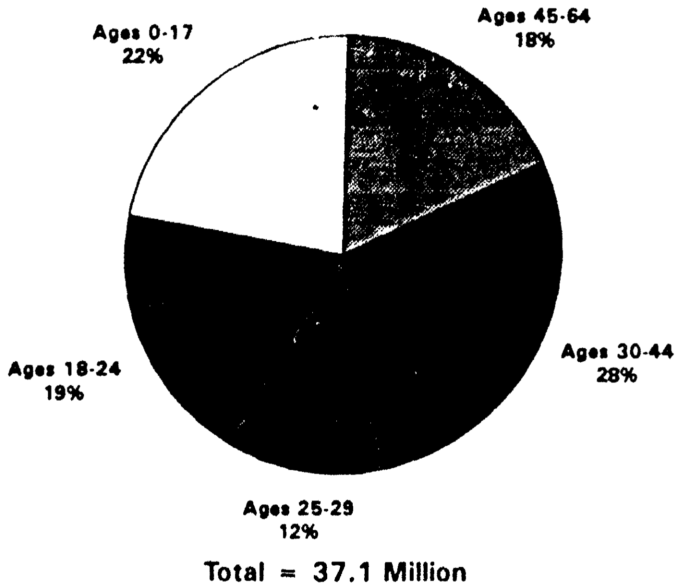


Total = 37.1 Million

Note: 1992 Federal Poverty Level was $11,570 for a family of three.
Source: The Urban Institute analysis of 1993 CPS.

Kaiser Health Reform Project

Figure 7: Distribution of the Uninsured, by Age, 1992

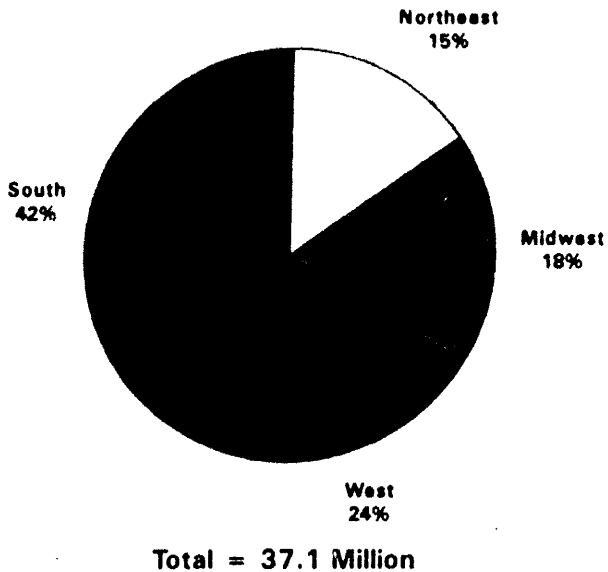


Total = 37.1 Million

Source: The Urban Institute analysis of 1993 CPS.

Kaiser Health Reform Project

Figure 8: Distribution of the Uninsured Population under Age 65, by Region, 1992

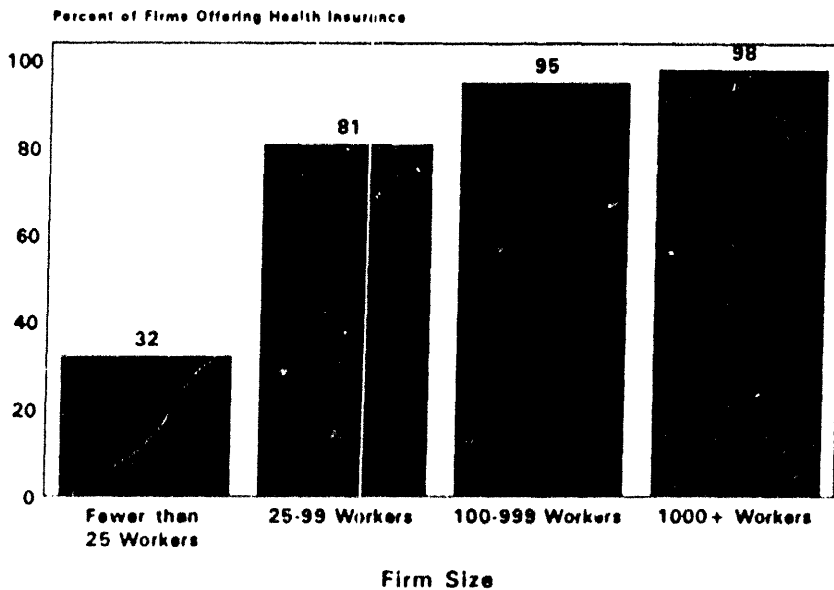


Total = 37.1 Million

Source: The Urban Institute analysis of 1993 CPS.

Kaiser Health Reform Projec

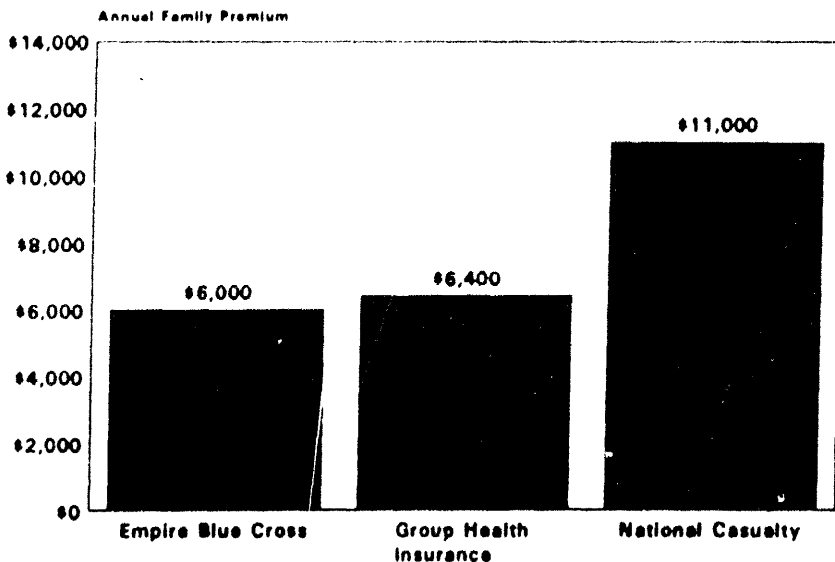
Figure 9: Percentage of Firms Offering Health Benefits, by Firm Size, 1991



Source: Health Insurance Association of America, 1991 Employer Survey.

Kaiser Health Reform Project

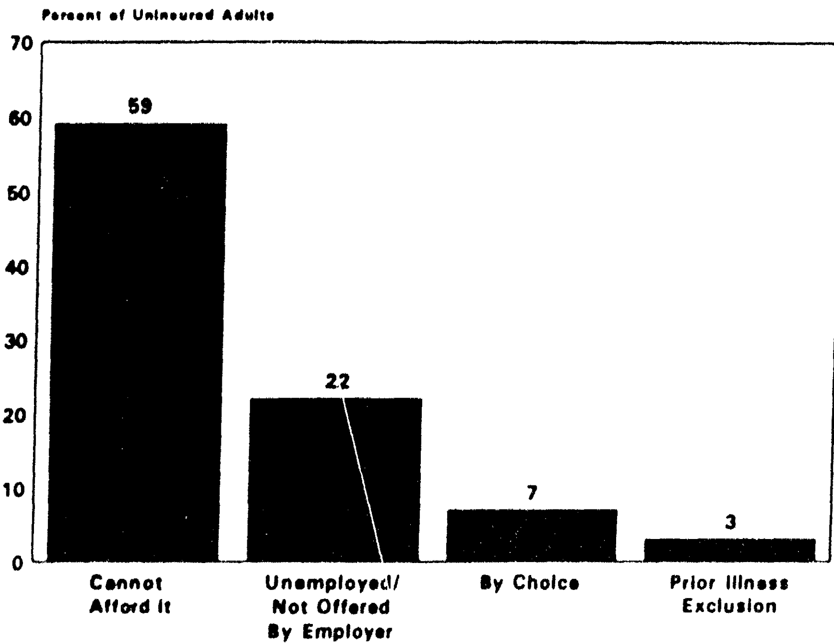
Figure 10: Selected Health Insurance Premiums for Non-Group Family Policies, New York City, 1993



Note: Indemnity policies have different deductibles and co-insurance levels.
Source: New York State HMO Commission, July 1993

Kaiser Health Reform Project

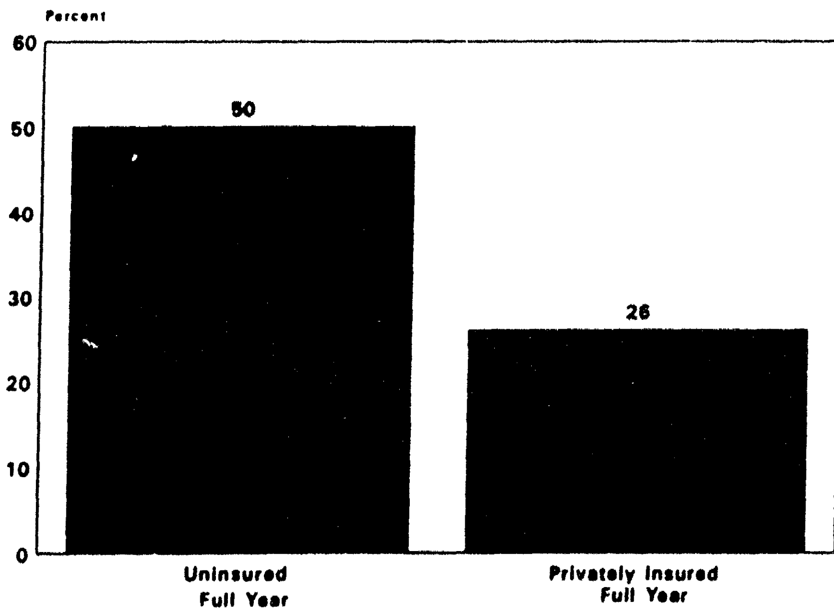
Figure 11: Primary Reason for Not Having Insurance, 1993



Source: Kaiser/Commonwealth/Harris Survey, 1993.

Kaiser Health Reform Project

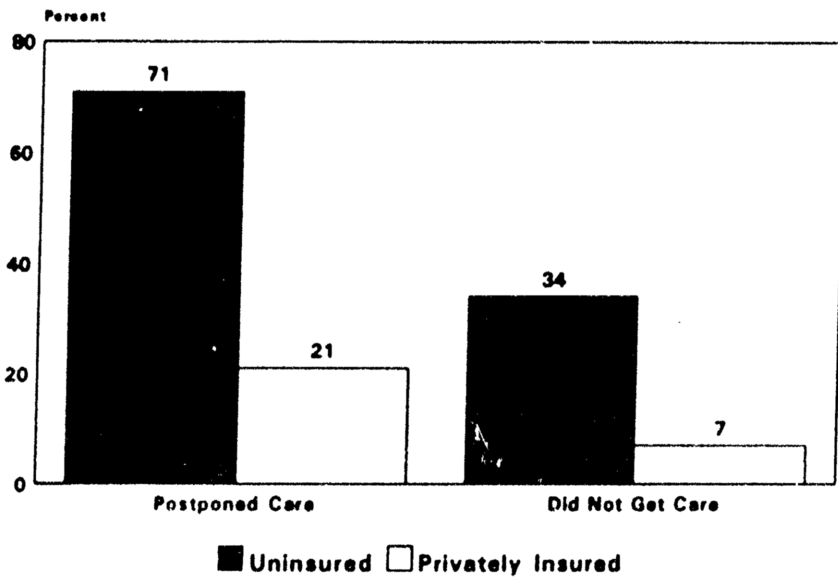
Figure 12: Percentage of Population under Age 65 with No Physician Visits, by Insurance Coverage, 1987



Source: Johns Hopkins University analysis of 1987 NMES.

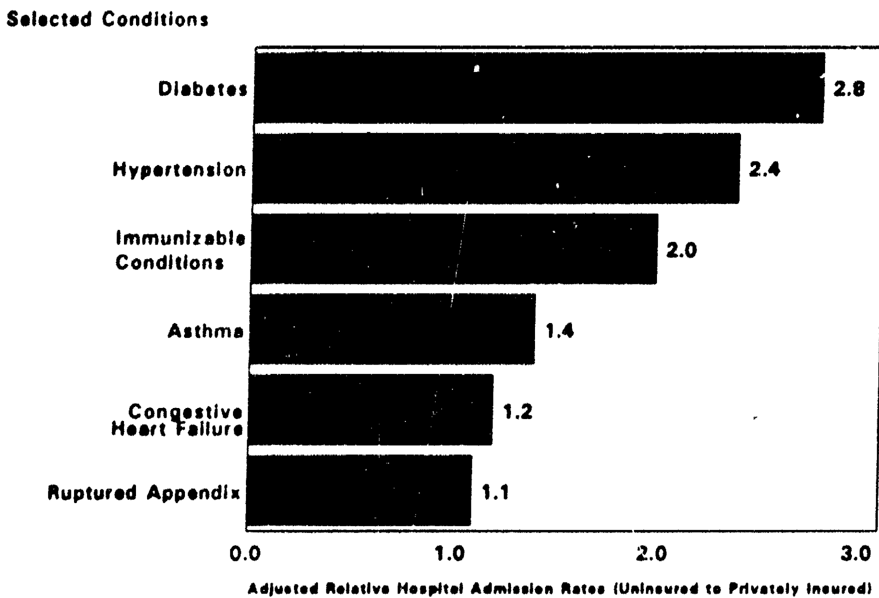
Kaiser Health Reform Project

Figure 13: Percentage of Adult Population Postponing or Foregoing Needed Medical Care in the Prior Year for Financial Reasons, 1993



Source: Kaiser/Commonwealth/Harris Survey, 1993. Kaiser Health Reform Project

Figure 14: Ratio of Uninsured to Privately Insured Hospital Admission Rates, 1987



Source: Weissman et al, JAMA 1992. Kaiser Health Reform Project

FIGURE 15: STUDIES EXAMINING THE RELATIONSHIP BETWEEN HEALTH INSURANCE AND HEALTH OUTCOMES

Citation	Study Population	Major Findings
Ayanian JZ, Kohler BA, Abe T, Epstein A. "The Relationship between Health Insurance Coverage and Clinical Outcomes among Women with Breast Cancer." *New England Journal of Medicine. 1993;329(5):326-321.*	Matched hospital discharge data and New Jersey State Cancer Registry for 4,675 women followed for up to seven years.	Upon diagnosis, uninsured women had significantly more advanced disease than privately insured women. Adjusted risk of death was 49 percent higher for uninsured women than for privately insured women during the four to seven years following breast cancer diagnosis.
Franks P, Clancy CM, Gold MR. "Health Insurance and Mortality: Evidence from a National Cohort." *Journal of the American Medical Association. 1993;1120(6):737-741.*	National Health and Nutrition Examination Survey Epidemiologic Study that followed 6,913 adults from 1971 through 1987.	Adjusted risk of death 25 percent higher for uninsured patients than for privately insured.
Hadley J, Steinberg EP, and Feder J. "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use and Outcomes." *Journal of the American Medical Association. 1991;265(3):374-379.*	National sample of 592,598 hospital discharge abstracts in 1987.	The uninsured were up to three times more likely to die in the hospital than comparable privately insured patients. The uninsured were 29% less likely to undergo a Coronary Artery Bypass Graft (CABG) surgery, and 45% less likely to undergo a total hip replacement than the privately insured, procedures subject to high physician discretion.
Weissman J, Gastonis C, Epstein A. "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland." *Journal of the American Medical Association. 1992;268 (17):2388-2394.*	Maryland and Massachusetts hospital discharge data from 1987.	In both states, uninsured patients with malignant hypertension had twice the rate of hospitalization than the privately insured. In Massachusetts, uninsured patients with diabetes had nearly three times the rate of hospitalization than the privately insured.
Wenneker MB, Weissman JS, Epstein AM "The Association of Payer with Utilization for Cardiac Procedures in Massachusetts." *Journal of the American Medical Association. 1990;264(10):1255-1260.*	Massachusetts hospital discharge data abstracts for 37,994 patients between 1985 and 1987 with principal diagnoses of circulatory disorders.	Uninsured patients were 80% less likely than privately insured patients to receive an angiography, 40% less likely to receive bypass grafting, and 28% less likely to receive an angioplasty.
Woolhandler S, and Himmelstein DU. Reverse Targeting of Preventive Care Due to Lack of Insurance." *Journal of the American Medical Association. 1988;259(17):2872-2874.*	10,653 women aged 45 to 64 from the 1982 National Health Interview Survey.	Uninsured women were found more likely to be inadequately screened for hypertension, cervical cancer, breast cancer and glaucoma than their insured counterparts.

Source: Kaiser Health Reform Project

PREPARED STATEMENT OF RAYMOND SCALETTAR

Mr. Chairman and Members of the Committee: My name is Raymond Scalettar, MD. I specialize in the practice of internal medicine here in Washington, D.C. and also serve on the Board of Trustees of the American Medical Association. Accompanying me today is Carol O'Brien, JD, of the AMA's Division of Federal Legislation. I appreciate the opportunity to speak to you today not only as a member of the nations largest physician organization with 300,000 members, but also as a doctor working in the District of Columbia, a region with one of the highest percentages of uninsured patients in this country. In this capacity, I know all too well that lack of health care insurance coverage prevents people, sometimes tragically, from getting needed care. This lack of health care coverage and access leads to higher rates of death and morbidity, much of which could be prevented or alleviated if these patients simply had been able to see a doctor sooner or had reasonable access to preventive care. The AMA has long called for comprehensive health system reform to achieve universal coverage for all Americans. In 1990, we proposed a reform plan called *Health Access America,* which called for extensive market-based health care reforms, including universal coverage that builds on our current employer-based health care system: insurance reforms, such as community rating and guaranteed portability; modification of ERISA, the federal Employee Retirement Income Security Act of 1974 (ERISA) to require the 65% of all health benefit plans that are self-insured to play by the same set of rules as state-regulated insurance plans; equitable financing of government health programs; and the establishment of state risk pools to provide affordable insurance to the uninsured and chronically ill with pre-existing conditions. Today, the nation still awaits action.

The AMA remains committed to working to see that our goal of universal coverage for all Americans under a standard comprehensive benefits package is achieved. Mr. Chairman, we agree with the President and Mrs. Clinton, many in Congress, and other patient advocates who believe the status quo can no longer be tolerated for the health of our patients and the nation. The statistics are chilling, and the numbers are slowly getting worse.

According to the Employee Benefit Research Institute (EBRI) in Washington D.C., an analysis of the U.S. Census Bureau's Survey of Income and Program Participation (SIPP), found that 32.1 million Americans were not covered by any type of health insurance on average in any given month of the fourth quarter of 1990. Similarly, the *Current Population Survey (CPS)* of the U.S. Department of Labor found that in the aggregate some 35.4 million Americans were uninsured in 1991. Most recent EBRI data just released last month shows that the ranks of Americans lacking health insurance has now soared from 37 million to 38.5 million in 1992. Although some of the increase was attributed to population growth. EBRI's assessment of the Census figures showed that the percentage of non-elderly persons who were uninsured and did not receive public assistance increased from 16.1% to 17.4%, indicating a significant change in insurance status. The decline in employment-based coverage was attributed to an uncertain economy, accompanied by increases in unemployment and the continually rising cost of health insurance.

The prospect of no health insurance has numerous policy implications that affect the number of people on welfare rolls and economic productivity, as well as health. Last year, a survey commissioned by the Kaiser Family Foundation found that one in five Americans are locked in their jobs for fear of losing their health insurance. More middle class and working poor are reluctant to leave current jobs or feel compelled to turn down employment offers because a new job's health coverage is more expensive or a new employer offered no insurance at all. Despite a basic tenet of American life that if you work hard, you can move up and better your lot in life, this study shows that for one in five Americans, the ladder up is blocked by the health insurance crisis.

These factors have hit patients hardest here in the District of Columbia and the rural states. In 1992, more than 20% of the population was uninsured in Washington, D.C., and 12 states, including the President's state of Arkansas, Alabama, Florida, Louisiana, Georgia, South Carolina, Texas, Nevada, Oklahoma, California, New Mexico, and Mississippi. Washington, D.C. has the fifth highest proportion of uninsured, at 25.5% of the population.

Studies also show, not surprisingly, that the uninsured comprise our most vulnerable patients. We know that the uninsured disproportionately reflect minorities, children, young adults, the chronically ill who are so often disenfranchised from health insurance under our current system, and the working poor. In 1989, 75% of the uninsured were in families with incomes below $30,000.

The studies also bear out what I and my physician colleagues know from experience. Patients who lack health insurance are at greater risk for premature death.

morbidity and higher emergency care and other costs. A study by the U.S. Agency for Health Care Policy and Research, a division of the Public Health Service. followed 4,700 adults representative of the population from initial interviews in 1971 through 1975 until 1987. By 1987, nearly twice as many uninsured patients died (18.4% versus 9.6% respectively). This study also showed that lack of insurance affected mortality at a risk level similar to the effects of a patient's education level, income, and self-rated health. These findings echo those of many other studies which show a correlation between lack of insurance and depleted access and quality of care. *Lives in the Balance,* a 1992 study by D. Hawkins of the National Association of Community Health Care Centers, found that the 17% of uninsured Americans had inadequate access to physicians, reflected in factors such as premature death and disability caused by controllable illnesses and higher rates of infant and child mortality. Moreover, the poor are more likely to be more seriously ill when admitted to the hospital, but more likely to also receive less aggressive care when hospitalized, according to another comparison study, published in *The Journal of the American Medical Association (JAMA)* in 1991 by J. Hadley, E.P. Steinberg and J. Feder.

These findings, among others, prompted the AMA's Council on Ethical and Judicial Affairs last year to reaffirm the ethical obligation of the AMA and of all physicians to assume some individual responsibility for making health care available to the needy. The AMA's first code of ethics provides that "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded." More recently, the AMA called on physicians to "continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care." Physicians have a long history of providing such care, and we are pleased to tell you today that this commitment continues. In reviewing the duty of doctors to provide care for the indigent, however. the AMA does not believe that individual philanthropy can cure problems that have complex origins and that require more extensive societal solutions. While doctors and medical organizations must continue to take steps, as many are doing now, to help relieve the distress and suffering that accompany medical indigency, increasing access to medical care alone will not solve the health problems of the indigent.

In 1994, as Congress considers a number of health system reform bills, the AMA is renewing its call for action. In January, 1994, we announced another proposal for advancement of our health system reform agenda, *Providing Health Coverage for All Americans,* which summarizes and underscores the core principles of our health system reform vision, and is attached to our statement today. That proposal emphasizes our commitment to ensure that health system reform builds upon a foundation of universal coverage with a standard set of benefits for every American and affirms the physician's role as patient advocate. Our approach to achieve that goal is multipronged.

First, the AMA advocates that all Americans should have access to a standard benefits package. The AMA recommendations, attached to our statement today, include comprehensive coverage for preventive services, based on an medically-developed age-appropriate periodic screening guidelines, including immunizations, screening tests, and smoking cessation programs; inpatient hospital care; outpatient care; and other benefits, including outpatient prescription drugs, skilled nursing facility services, and hospice care.

We support limiting tax deductibility of employer/employee-provided health insurance to an appropriate ceiling such as 125% to 133% of the geographically-adjusted costs of the required standard benefits package. We support assistance for smaller firms, including sequential phase-in of coverage requirements, tax incentives to make the provision of a benefits package manageable, a choice of benefit plans in three actuarially equivalent forms as available, including a benefit payment schedule, a pre-paid HMO/PPO approach, or a UCR plan, and the incorporation of meaningful patient cost-sharing (except for preventive care) to encourage prudent health care decisions.

To advance universal coverage under a standard benefits package, the AMA supports a variety of financing approaches. including an employer mandate, an individual mandate, use of health IRAs or medical savings accounts (MSAs), or any combination of these or other mechanisms. While the AMA continues to support a requirement for employers to contribute to the financing of health care coverage for employees, we also advocate flexibility in emerging health system reform policy to determine the relative responsibilities of individuals, employers, and government in achieving universal coverage. We have not endorsed any health system reform legislation, but we believe that all approaches, including the employer mandate contained in the Mitchell/Gephardt bills, S. 1757 and H.R. 3600, and the individual mandate contained in the Chafee/Thomas bills. S. 1770 and H.R. 3704. should be

evaluated. We believe legislation to establish MSAs can also be effectively integrated into a health system reform that meets our goal of universal coverage.

A multi-faceted approach that builds on our current private system which now provides the best quality of health care in the world is the most complete and cost-effective way to achieve universal coverage in the U.S.—a nation that combines a high degree of technology with an extremely diverse nation encompassing large geographic boundaries. A health system reform plan must be adaptable to our nation's unique needs, its patients and physicians. As the President noted in his State of the Union address, a workable, long-term approach must be linked with welfare reform to ensure that individuals do not have incentives to stay on welfare in order not lose their health care coverage.

Similarly, health system reform efforts will not be successful unless they are linked with systemic efforts to end the drain on health care resources caused by the grave public health problems of this nation—violence, rampant crime, easy access to handguns and ammunition, AIDS, tobacco, substance abuse,poverty, homelessness and teenage pregnancy.

We applaud the President and Mrs. Clinton for their resolve to address the problems of lack of health care insurance coverage and access in America, and in taking the first steps to end the status quo. It is encouraging to physicians that the President and Members of Congress have signalled a willingness to negotiate details of the plan, so long as compromise does not undermine the basic principle of universal coverage. We, too, are committed to that vision, and we look forward to working together with the President, the Congress and others to forge creative solutions to our health care coverage and access difficulties.

We recommend that in the effort to change the system, one model of U.S. success should not be overlooked. In the State of Hawaii, where 97% of the population has health care coverage, universal access has been accomplished to a great extent. Hawaii has realized this goal through use of an employer mandate and extensive insurance reforms, including community rating and a waiver from ERISA, which allows a level playing field for beneficiaries and increased access to affordable insurance. Public support for Hawaii's system is strong in the state, according to a number of recent polls conducted by Louis Harris and Associates, and sponsored by the Kaiser Family Foundation and the Queen Emma Foundation. While Hawaii has unique population characteristics, its overall health care system, hospital costs, provider salaries, and standards of care are typical among the states. However, Hawaii's commitment to universal access, community insurance rating, and primary and preventive care has paid unexpected cost-containment dividends in addition to the social rewards. This experience deserves consideration by national policy-makers.

We believe that the Hawaii experience demonstrates that the AMA's vision of health system reform can succeed. The Hawaii results suggest that:

- an employer—or some other mandate—can be a powerful means of increasing access without a devastating impact on business;
- fair insurance practices are essential;
- a broad standard benefits package, emphasizing primary, outpatient and community care, but including a comprehensive spread of benefits extending from inpatient to catastrophic care, is necessary to contain overall costs;
- universal access is in itself a cost-containment strategy. Hawaii's 20-year experience demonstrates that ongoing access reduces the need for acute care: utilization of high-cost services is well below the rest of the nation;
- ERISA reform to level the playing field among health insurance plans is critical.

The AMA urges Congress to consider the Hawaii model as a positive and non-hypothetical model of health system reform in America. We believe this experience, properly constructed, can be validated on a national level, while still protecting patients' access to the physician and health care plan of their choice and to quality care.

Whatever compromises may be made, certain principles must remain to achieve health system reform. The AMA advocates that the following principles must be included in reform legislation:

- universal coverage offering a standard set of health benefits;
- a private/public system that creates competitive forces to constrain rising health care costs;
- insurance reform, including guaranteed portability of coverage; and
- affirmation of the physician's role as patient advocate;
- antitrust relief to allow physicians to negotiate without engaging in price-fixing or boycotts to form physician sponsored/directed health care delivery networks

and health plans, to determine appropriate clinical protocols and fee schedules, and to engage in negotiated rule-making.

The task before us to achieve these goals is indeed enormous. The AMA recognizes that the health system reform vision we support and are committed to undertake with you is of momentous, historic proportions. We agree with many observers that this task may well be the greatest challenge—and if we reach it—the greatest accomplishment of the last 25 to 50 years of the 20th Century. The AMA looks forward to working with you to meet this challenge head on as we approach what we all hope will be a new and improved health care system for our children and for all Americans in the 21st Century.

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American Medical Association
Physicians dedicated to the health of America

Providing Health Coverage for All Americans

Health System Reform Proposal for Action

In 1990, the American Medical Association (AMA) called for comprehensive health system reform in its proposal, "Health Access America". We're still waiting for action. Many Americans are still shut out of our health care system; millions of others face the problem of staying in a job simply because it offers decent health insurance; others are financially ruined because of devastating health care expenses. Changes in the marketplace are also jeopardizing patients' freedom to reach health care decisions with their physicians and replacing physicians' clinical judgment and decision-making expertise with corporate cost-cutting concerns.

To remedy these problems, the AMA urges Congress to pass a health system reform bill that: (1) has as its centerpiece universal coverage for a standard set of health benefits for every American, regardless of employment or economic status; (2) creates a health care system where competitive forces act to constrain rising health care costs; and (3) affirms the physician's role as patient advocate. We present this current reform proposal to accelerate legislative debate and action. We pledge to work with the Administration and the Congress in 1994 to advance these goals.

Our proposal also recommends a significant role for physicians as patient advocates in shaping policy, health care payment and delivery decisions under a revamped health system. If physicians are going to be successful advocates for their patients in ensuring access to high quality, affordable health care, they must have a strong voice on issues relating to the delivery of and payment for care. In managed care and other delivery arrangements, patient-physician decisions must prevail over economic considerations.

The AMA reform proposal is intended to:

- Achieve universal health care coverage for all Americans;
- Strengthen the voice of physicians in clinical judgment and decision-making to balance the ever-increasing corporate domination of health care;
- Promote compromise and flexibility to achieve universal coverage and to design the best approach to shared responsibility of employers, individuals, and government in paying for health care coverage;
- Slow the rate of growth in health spending through competition in the marketplace;
- Effect major professional liability reform to reduce the inappropriate cost of defensive medicine and liability insurance premiums;
- Assure that all Americans have choice of health plans and physicians;
- Provide individuals with price and quality information to make informed health care decisions; and
- Create a more efficient, streamlined, and coordinated health care system.

Our proposal recommends the following fundamental changes to our health care system.

Universal Coverage

Health care coverage must be extended to all Americans. We support a variety of approaches to achieve this goal: an employer mandate, an individual mandate, and health IRAs. As the congressional debate unfolds, flexibility will be needed in determining the relative responsibilities of individuals, employers, and government to ensure universal coverage with a standard set of health care benefits for all Americans.

Insurance Market Reform

To ensure that insurance carriers can no longer deny coverage to individuals with chronic or other medical problems, or refuse to renew such coverage -- and to even out the affordability of health insurance premiums -- the following insurance market reforms are essential:

- Implement community rating; and
- Eliminate pre-existing condition limitations so individuals with chronic or other medical problems can secure and keep private health insurance.

Health Insurance Purchasing Cooperatives

- The insurance market reforms we advocate are similar to those that have worked successfully in Hawaii; specifically community rating, elimination of pre-existing condition clauses, and portability of coverage. To the extent these reforms are adopted -- particularly community rating which would make insurance available to all at no more than a community-established premium -- then health insurance purchasing cooperatives would serve primarily to disseminate information to the public. Without such insurance market reforms, voluntary private sector health insurance purchasing cooperatives are desirable so that small firms and individuals can benefit from the market power of group purchasing. Under such a purchasing cooperative approach, competing cooperatives in the same geographic region are essential to ensure that no one giant purchasing conglomerate could monopolize the market, thereby reducing competition and consumer control of health care decisions.

Physician Involvement in The Health Care System
Antitrust Relief
Physician-Directed Networks
Negotiated Rulemaking
Self Regulation

Today's health care marketplace is increasingly characterized by corporate, and often for-profit, organizations and large managed care plans that are taking aggressive action to control the delivery of health care services and reduce their costs. While efforts to save costs are appropriate and desirable, excessive concern for costs can interfere with the availability and delivery of health services to patients and diminish the quality of those services.

If physicians are going to be successful advocates for their patients in ensuring access to high quality, affordable health care, they must have a strong voice on issues relating to the delivery of and payment for care to balance the ever-increasing corporate domination of health care.

Under the current antitrust laws, however, physicians who engage in negotiations are threatened with criminal prosecution or costly civil litigation. This state of affairs is simply unacceptable as a matter of health care policy and fundamental fairness. To correct this situation and to foster meaningful reform whereby treatment decisions are made on the basis of what is best for the patient -- not what is best for the corporate bottom line -- we propose the following:

- Enact legislation that facilitates the formation of physician sponsored/directed health care delivery networks and health plans. This legislation should authorize physicians to form these entities and provide exemptions from regulations that interfere with this activity.

- Reform the antitrust laws to allow for safe harbors similar to those developed by the Department of Justice and Federal Trade Commission, but expand the safe harbors for the formation of physician groups representing up to 35% of the physicians in a market in exclusive networks, and 50% in nonexclusive networks. Such percentages may need to be adjusted upward in rural areas.

- Enact legislation to direct non-physician sponsored health plans to create committees, similar to a hospital medical staff, of practicing physicians in the plan to provide input about coverage, medical review criteria for individual coverage decisions and credentialing of physicians, administrative procedures, physician payment, and other matters. The legislation would recognize the right of physicians to make presentations to health plans that has been provided for in federal judicial decisions.

- Legislation also should be established under federal law for negotiated rulemaking, backed up by binding arbitration for dispute resolution, as the primary method for developing federal health care regulations, with the AMA acting as the profession's lead negotiator. Such mechanisms would not establish -- nor would it be to the benefit of patients or physicians to establish -- any "right to strike" by physicians.

- Standard setting should be performed by physician organizations in such areas as the development of practice guidelines, outcomes measurement and reporting, and performance standards. The development and application of standards for medicine is an area where the profession has excelled, particularly in the accreditation of medical education and health care institutions. This method is highly effective on a performance and cost basis. As part of this, medical societies should be allowed to conduct medical peer review activities and mediate fee disputes between patients and physicians for purposes of professional self regulation and discipline.

Professional Liability Reform

Defensive medicine, the ordering of tests and procedures which might not be ordered were it not for liability concerns, drives up health care costs. Liability insurance premiums and defensive medicine activities add significantly to the average physician's bill for services. According to Lewin/ICF, the cost of defensive medicine activities performed by physicians totaled $25 billion in 1991. These unnecessary costs are passed on to patients and contribute to rising health care spending.

Major liability reforms -- similar to those enacted in California in 1974 -- must be enacted to control these costs. California's experience has proven that such reforms significantly reduce physician's liability insurance premiums. Prior to enactment of California's liability reforms, physician's professional liability premiums were roughly equivalent in California and New York. Today, physician's average liability premiums are about 40 percent higher in New York than in California, with differentials of up to three to five times in some specialties (such as obstetrics and neurosurgery).

Our proposal specifically recommends:

- A $250,000 cap on noneconomic damages;

- Mandatory periodic payment of future elements of damages;

- A mandatory offset of collateral sources, such as health insurance and disability benefits when computing compensation to prevent double recovery of damages;

- A sliding scale limit on attorneys' fees in relation to the size of the award;

- A statute of limitations, applicable to adults and minors, to limit the time period for filing claims;

- A certificate of merit as a prelude to filing medical liability cases and adopting basic criteria for medical expert witnesses;

- Encouragement of patient safety issues as an integral component of outcome and quality assessment programs; and

- Providers following clinically relevant practice parameters developed by professional associations should be allowed to raise such compliance as an affirmative defense in liability actions.

Quality of Care

The quality of health care in the United States remains unsurpassed -- and is one of the greatest strengths of the American health care system. To ensure this continued level of excellence, physicians and their professional organizations should continue to control the standards for quality care delivered to patients. Such standards will help to assure that only appropriate medical services are provided, thus impacting favorably on the quality and cost of medical care.

Our approach presents a public/private partnership to enhance quality, rather than creating any new federal bureaucracy or new systems for accountability that would fail to recognize existing quality improvement and accreditation programs.

Our reform proposal includes:

- A defined role for organized medicine and practicing physicians on any national public or quasi-public body dealing with quality issues;

- A provision for input by the medical profession in the development, implementation, and evaluation of quality management programs at the state and health plan levels;

- A provision for input from consumer and patient representatives about quality issues (e.g., access to performance data, confidentiality of medical records, satisfaction with physicians and other providers);

- Establishment of a private/public partnership to implement a national quality program that strengthens existing private sector efforts in quality, utilization and outcomes management -- instead of government control over quality programs. This partnership establishes a national advisory body on quality of medical care and will provide for the exchange of information among quality programs, oversee the establishment of performance measurement systems, and shall have deemed status to accredit and approve quality programs. The partnership would:

  - Develop principles for quality management;

  - Develop principles for outcomes measurement and reporting, including the content and format of electronic patient records, and guiding and coordinating efforts to gather outcomes data;

  - Develop mechanisms, such as provider report cards, to assure the public availability of information and to inform patients and purchasers about local health plan performance and to promote both quality and competition in the marketplace;

  - Develop interventional tools and education programs to change practice patterns;

- Develop strategies for and coordinating effectiveness research and technology assessment;

- Develop principles of utilization management; and

- Establish priorities for guideline development through analysis of variations in practice.

Freedom of Choice

Currently, too many individuals have only limited choice of health plans offered by their employers and their access to physicians under these plans also is often restricted. In a reformed system, the individual -- not the employer -- should have the right to select from all qualified health plans in their area, including fee-for-service, HMO, PPO, and benefit payment schedule plans. This will ensure that individuals are able to choose both their physician and their preferred method of paying for health care.

Our proposal specifically recommends that:

For Patients

- Individuals shall be entitled to select from any qualified health plan -- fee-for-service, PPO, HMO, or benefit payment schedule -- offered in their geographic area.

- All health plans, including HMOs, must offer individuals the option of purchasing a "point of service" rider. This rider, which must be offered by plans at time of enrollment and at least annually thereafter, would entitle individuals to seek care from any physician -- whether in or out of the plan -- and have coverage for such care as defined in the comprehensive benefit package.

- Any health plan restriction of access to services or providers must be disclosed to and acknowledged by the enrollee.

- All insurers and health plans must pay for case management services/coordination of care delivered by qualified health care professionals to promote more coordination of services across specialties for the benefit of patients.

For Physicians

- Physicians shall have the right to apply to any health plan or network and to have that application approved if it meets physician-developed objective criteria that are available to both applicants and enrollees and are based on professional qualification, competence, and quality of care. However, health plans or networks may develop and use physician-developed criteria to determine the number, geographic distribution, and specialties of physicians needed.

- Managed care organizations and third-party payers shall be required to disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed.

- Health plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians shall report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, costs, and choice of health care services provided to patients enrolled in such plans or networks.

  - In any case in which selection criteria, especially economic criteria, may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken.

- Managed care plans and medical delivery systems must include practicing physician involvement in their health care delivery policies similar to those of self-governing medical staffs in hospitals. Physicians participating in these plans (and no physicians should be arbitrarily excluded) must be able, without threat of punitive action, to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including practicing physician representation on the governing board and key committees of the plan.

Cost Containment

Rising health care expenditures are driven by many factors: inflation, new and expensive technology, and health conditions associated with increasing societal problems such as violence, drug abuse, poverty, and HIV infections. For too many individuals, the rising costs threaten their access to needed services and their ability to pay for medical care.

Our proposal's approach to cost containment focuses on increasing competition in the marketplace. The proposal would foster competition by:

- Encouraging cost-conscious decision-making by patients through the provision of clearly-understandable price information for physician, hospital, and other services and the extent of insurance payment for covered services. Insurance companies and physicians that use a relative value scale methodology could make available to the public their conversion factor and other necessary information so that patients can determine the extent of insurance payment for a particular service;

- Requiring employers and insurers to offer individuals a choice of health plans and financing mechanisms.

The AMA proposal would also:

- Establish a negotiated goals approach -- rather than premium caps or strict global budgets -- that involves physicians in establishing reasonable health care spending goals that take into account demographics, disease, technology, and demand factors.

  - Such a negotiated approach is in direct contrast to strict global budgets or spending caps -- both of which would result in rationing of health care services and would conflict with society's obligation to ensure that no American goes without health care coverage.

- Utilize practice parameters and utilization guidelines to enhance quality, cost-effective and outcome-effective care.

- Establish that for those individuals below 200 percent of the federal poverty level, insurance payment must be accepted as payment in full.

- Effect major professional liability reform to reduce the inappropriate costs of defensive medicine and liability insurance premiums.

- Simplify the system through reduction of paperwork and government regulation and standardization of managed care requirements, claims procedures, review practices, and disclosure policies.

- Create a level playing field for the self-insured and the insured alike through the amendment of ERISA to assure provision of secure, standard benefits and fairness of treatment for all.

- Cap the deductibility of employer-provided health insurance at an appropriate ceiling such as 125 percent to 133 percent of the geographically-adjusted costs of the required comprehensive standard benefit package. This cap would apply to the employer and the employee and would foster prudent use of services and raise needed revenue to fund coverage for currently uninsured and underinsured Americans.

Scope of Practice

The AMA supports appropriate collaboration among physicians and other health professionals within the scope of their education and training to achieve the best results for patient care. Determinations of "appropriate" collaboration should be mutually-developed through interdisciplinary discussions.

Standards for determination of scope of practice for various health professionals should be established at the state level, including provisions that would preclude inappropriate restriction of practice by those professionals demonstrating educational and clinical competence.

Our proposal specifically recommends:

- National studies to identify those programs where physicians, nurses, and other health professionals have been working on a collaborative basis both successfully and unsuccessfully and to disseminate such information broadly.

- These studies should also provide support for the interdisciplinary discussions on a mutually-acceptable definition of "collaborative practice" and for discussion of such issues as reimbursement for services and the identification of advance practice nursing roles in the hospital and community settings.

Physician Workforce

Currently, there are an inadequate number of physicians in primary care specialties. This problem needs to be addressed. Our proposal specifically recommends:

- A private sector consortium/initiative, independent of control by any single group, that would develop positive incentives (e.g., loan forgiveness) to increase the proportion of physicians who enter and remain in primary care specialties and practice in underserved areas.

- Preservation of student and resident freedom of specialty choice -- in contrast to the imposition of workforce quotas and the use of negative sanctions.

- Participation by all payers in the funding of graduate medical education.

Simplifying the System

The current health care system is fragmented, costly, complicated and characterized by duplicative and confusing paperwork and government regulations. To allow more time for patient care activities -- and to improve access and help contain health care costs -- administrative simplification must be a core element of any health system reform initiative. Our proposal includes the following specific changes:

Administrative Changes

- Reduce the complicated paperwork nightmare faced by patients and their families by requiring that all insurers and the government use a simple, uniform claim form.

- Provide incentives to encourage physicians and other providers to file benefit claims on behalf of their patients.

- Provide incentives to encourage health insurers to use a standard electronic billing format and to encourage physicians to utilize this method of filing claims on behalf of their patients.
- Standardize and disclose utilization review criteria to patients and physicians.
- Reduce the regulatory and costly burden of unnecessary government programs.

Financing Reform -- Who Will Pay?

The provision of health coverage to all Americans could be assured through a variety of approaches, such as through a blending of responsibilities of employers, individuals, and the government. There is no single best mechanism. Revenue for expanding coverage to all Americans would be generated by the AMA recommended employee/employer tax cap and an excise tax of at least $2 per pack on cigarettes. As necessary, additional revenue for financing the government's contribution to universal health care coverage could be raised from broad-based taxes -- rather than inappropriate spending reductions in the Medicare and Medicaid programs.

In Sum, The Time for Action Is Now

This proposal offers a comprehensive solution to reforming our health care system that blends competitive forces in the marketplace with societal responsibilities to ensure affordable health care coverage for all Americans. This proposal would also reaffirm the physician's role as patient advocate and reinstate the patient's right to reach health care decisions with their physician unencumbered by corporate decisions that often place profits above patients.

We call upon all parties to seek common ground in establishing an improved health care system for all. We stand so ready. We strongly urge the Congress to pass a health system bill that: (1) has as its centerpiece universal coverage for a standard set of health benefits for every American, regardless of employment or economic status; (2) creates a health care system where competitive forces act to constrain rising health care costs; and (3) affirms the physician's role as patient advocate. We pledge to work with the Administration and the Congress in 1994 to advance these goals.

Summary of Coverage
AMA Standard Benefits Package
January 1, 1994

Benefit	Coverage
A Preventive Services	
Ages birth to 5 years	Thirteen physician health examinations/counseling at intervals recommended by American Academy of Pediatrics
	Immunizations/Chemoprophylaxis: DPT; MMR; HIV; HBV; oral or injected polio vaccine.
	Tests/screening: hematocrit; lead; metabolic screening; urinalysis; TB and cholesterol for high risk groups
Ages 6-10 years	Three physician health examinations/counseling at intervals recommended by American Academy of Pediatrics
	Immunizations/chemoprophylaxis: Td; oral or injected polio vaccine.
Ages 11-21 years	Yearly physician examinations/counseling as recommended in AMA Guidelines for Adolescent Preventive Services.
	Immunizations/Chemoprophylaxis: Td; HBV and MMR for high risk groups.
	Tests/screening. Annual STD screening (gonorrhea, chlamydia), and pap smear if sexually active; TB, cholesterol, syphilis, HIV, HBV for high risk groups.
Ages 22-39	Physician health examinations/counseling every 1-3 years at physician's clinical discretion.
	Immunizations/Chemoprophylaxis: 1 Td every 10 years; additional specific immunizations for high risk groups

	Coverage
Ages 40-64	Tests/screening: Cholesterol every 1-3 years; Pap smear every 3 years following 3 negative yearly findings; 1 screening mammogram between ages 35-39; additional specific tests for high-risk groups.
	Physician health examinations/counseling every 1-3 years at physician's clinical discretion.
	Immunizations/Chemoprophylaxis: 1 Td every 10 years; additional specific immunizations for high risk groups.
Ages 65+	Tests/screening: Cholesterol every 1-3 years; Pap smear every 1-3 years; 1 screening mammogram every 2 years for ages 40-49 and yearly for ages 50-64; intraocular pressure measurement (IPM) yearly; fecal occult blood and digital rectal exam yearly after age 50; prostate specific antigen (PSA) every 3 years after age 50; sigmoidoscopy every 3 years after 2 yearly negative findings after age 50; additional specific tests for high risk groups.
	Physician health examinations/counseling yearly.
	Immunizations/chemoprophylaxis: 1 TD every 10 years; influenza vaccine yearly; pneumococcal vaccine; HBV for high risk groups.
Pregnant Women	Tests/screening: cholesterol yearly until age 70, and at physician's discretion thereafter; dipstick urinalysis yearly; 1 screening mammogram every 2 years; IPM yearly; fecal occult blood and digital rectal exam yearly; PSA every 3 years to age 70; sigmoidoscopy every 3 years after 2 yearly negative findings to age 80; thyroid function tests yearly for women; additional specific tests for high risk groups.
	Physician health examinations/Counseling: initial prenatal visit plus followup visits at physician's clinical discretion.
	Tests/screening: blood pressure, hemoglobin/hematocrit; ABO/Rh typing; RH (D) and other antibody screening; VDRL/RPR; HBsAg; urinalysis; gonorrhea culture; rubella antibodies; chlamydia testing at first prenatal visit. MSAFP at 14-16 weeks gestation; glucose tolerance test at 24-28 weeks; additional specific tests for high risk groups at 14-16, 24-28 and 36 weeks gestation.

Benefit	Coverage
B. <u>Inpatient Care</u>	
<u>Hospital</u>	Unlimited hospital days in semi-private room; ICU, operating and other treatment rooms; drugs and medical supplies/equipment; technical costs of imaging, laboratory, other diagnostic tests; anesthesia; blood/blood products. Not covered: custodial, convalescent or domiciliary care; medically unnecessary hospitalizations.
<u>Surgical</u>	Surgery including pre-and post-operative care; diagnostic procedures and oral surgery; [1 specific organ transplants; anesthesia services; reconstructive surgery. Not covered: Radial keratotomy, cosmetic surgery.*
<u>Medical</u>	Medical care by attending physician, and concurrent care; consultations; including imaging and professional clinical laboratory and pathology services; physician-directed rehabilitation services--physical, occupational and speech therapy.
<u>Maternity</u>	Same hospital benefits as for illness or injury. Physician care and anesthesia services. Oral contraceptives and contraceptive devices; sterilization procedures; diagnosis/treatment of infertility. Not covered: in-vitro fertilization; artificial insemination; embryo transfer; reversal of voluntary sterilization
<u>Mental Conditions/Substance Abuse</u>	Same hospital and physician care benefits as for other illness, except: Inpatient treatment for substance abuse limited to one 28-day treatment program, up to ~~$3,000 per lifetime~~ Not covered: Marital or educational counseling/services; halfway house services.

* As defined in Policy 475.992 and in accord with AMA Policy 55.992 (AMA Policy Compendium)

Benefit	Coverage
C. Outpatient Care	
Hospital	Unlimited outpatient department admissions; imaging, laboratory and pathology services, radiation and chemotherapy, renal dialysis, and outpatient surgery including anesthesia in hospital, freestanding facility or physicians office; blood/blood products.
Surgical	Physicians' surgical services same as under inpatient care.
Medical	Unlimited physician office and home visits; outpatient consultations; second surgical opinions. Physicians' services for radiation and chemotherapy, renal dialysis. Physician-directed physical, occupational and speech therapy, combined total of 25 visits. Family planning services. Allergy tests and injections.
Maternity	Outpatient hospital care, including birthing centers; same physician, ancillary and other services as in inpatient maternity care.
Mental Conditions/Substance Abuse	Unlimited outpatient visits with physicians for individual or group therapy, including related services and supplies. Day-night hospital services
Home Health Care	90 days per year of following services provided by home health agency: nursing care; physician-directed rehabilitation services--physical, occupational and speech therapy; respiratory or inhalation therapy; prescription drugs; other medically necessary medical services or supplies including physician-prescribed home glucose testing equipment. Not covered: home care for mental conditions/substance abuse, maternity, initial evaluation/monitoring; homemaker services.
D. Outpatient Accidental Injury Care	Physician services in office or outpatient department, including related imaging and other diagnostic services, within 72 hours of accidental injury.
E. Prescription Drugs	Outpatient prescription drugs, including insulin.
F. Dental Care	Dental services required due to accidental injury.

Benefit	Coverage
G. Additional Benefits	Ambulance for inpatient admissions, during home health care or for medical emergencies including accidental injury. Durable medical equipment; prostheses; prescription orthotics, cochlear implants. Not covered: Exercise and bathroom equipment; seat lift chairs; air conditioners and purifiers; wigs; computer devices for communication impairments Skilled Nursing Facility: up to 180 days per person per year. Hospice care: physician, nursing, medical social, physical therapy and home health aide services; durable medical equipment/supplies; prescription drugs. Up to 5 days hospital or inpatient hospice care. Not covered: Homemaker or bereavement services. Smoking cessation treatment from physician, clinic or other covered provider; one per lifetime for $100 maximum payment.

1] Limited to the following surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is required.
- Surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.
- Excision of exostoses of jaws and hard palate.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands or ducts.
- Reductions of dislocations and excision of temporomandibular joints.
- Removal of impacted teeth.

PREPARED STATEMENT OF GERALD M. SHEA

My name is Gerald M. Shea and I am the Director of the Employee Benefits Department of the American Federation of Labor and Congress of Industrial Organizations. The AFL-CIO is comprised of over 80 affiliated international unions, which in turn represent over 14 million U.S. workers. Together, the unions of the AFL-CIO negotiate health benefits for over 38 million people. On behalf of our membership, I want to thank Chairman Moynihan and the other members of the committee for this opportunity to testify today. I hope that the experience of organized labor's decades-long battle to extend health coverage to all Americans will be of assistance to you in your deliberations.

Health care coverage has long been a priority issue for American unions. We stand squarely behind the principle that health care is the right of all human beings—that it is a social good of such far-reaching importance that it should be assured by society.

Recent discussions of our health care crisis have focused, understandably, on economic aspects of the problem. Most of our comments today will be in this vein. But we find that the ethical question of health coverage is all too often ignored, and those discussions are worse off for it. As stated by the Catholic Bishops of the United States, "health care is more than a commodity; it is a basic *human right,* an essential safeguard of human life and dignity." Access to care when we are sick should not depend on whether we are young or old, employed or unemployed, rich or poor. It is this lack of health insurance coverage for all Americans, coupled with runaway health care cost inflation, that has led us to the crisis in our current system.

The effect that the lack of health coverage has on individuals, their ability to advance themselves, provide for their families, and contribute to the common good, are so profound that no country which fails to assure universal coverage can be said to have met all its obligations.

Beyond the moral basis for universal coverage, there are severe economic consequences for failure to do so. Unions, which play a prominent role in the provision and financing of health care for workers, have experienced the economic distortions of our not achieving universal coverage—higher health costs among the insured, an erosion of wage standards, and uneven competition among economic enterprises, where irresponsible employers without health plans for their workers enjoy an advantage over those employers that provide them.

Our belief in the critical importance of adequate health coverage, and our experience in negotiating wage and benefit packages with employers, led us to the position long ago that a social insurance program for health coverage would be the most successful, most efficient, and economically most equitable. We stand by that position today.

We were strong supporters of the Murray-Wagner-Dingell bill (S. 1161—H.R. 2861) legislation in the 1940's, and later, of President Truman's proposal for national health insurance.

Labor's support for a national health care program has remained constant over the ensuing fifty years. But the country's failure to support such initiatives led us to concentrate most of our day-to-day efforts on a "second best" approach—private health insurance plans established through collective bargaining. This was the historical setting for the rise of the employment-based health care system by which the majority of Americans receive their health care coverage.

Beginning in the years following World War II, unions and employers began to build a network of coverage which grew steadily through the fifties, sixties, and seventies. At first through sharp industrial conflict and later through labor-management cooperation, the number of American workers with health care benefits increased steadily. And coverage was extended to the dependents of workers. As new medical procedures and new types of insurance coverage became available through the market, these were added to negotiated health plans.

By 1980, 154 million Americans, or 80 percent of the population received health benefits through their, or a family members' place of employment. But rapidly rising health costs ended the growth of employment-based health care by 1985.

The run-up in health costs in the early eighties saw a sharp rise in the number of strikes over health care. By the late eighties health care had become the number one strike issue in the country, with the percentage of strikes where health care was a primary issue rising form 18 to 78 percent from 1986 to 1989.

In reaction to this increase in industrial conflict caused by health costs, a new pattern of labor-management cooperation also arose, as both sides worked together to pioneer cost containment strategies such as utilization review, second opinion programs, and many others. These early steps represented the beginning of the

managed care era in American health care. While these measures showed some short term success, they were unable to blunt the long term rise in costs.

Traditionally, unions have played a major role in expanding health coverage by bringing new groups of workers under health plan coverage through first contracts. Once covered, workers' health benefits were expanded to include dependents and additional benefits. In years past, unions have been able to perform both these functions at the same time as improving the real wages of workers.

High health costs have all but stopped unions from being able to play our traditional role in improving workers' health care coverage and was a significant factor in the loss of real wages experienced by most American workers in the 1980's.

It's become all but impossible to bring newly organized groups of workers under coverage. Companies that provide health insurance coverage to their workers are simply placed at too much of a competitive disadvantage vis-a-vis companies that do not provide coverage. Unless an entire industry provides health benefits to their workers, companies that provide coverage can not compete with companies that do not. By the same mechanism, when one company in an industry cuts benefits, other companies come under great pressure to follow suit in order to continue to compete effectively. One example of this process is the pressure on companies to reduce or eliminate health care coverage for their early retirees.

Excessively high health costs also have forced unions in every industry into a defensive posture in regard to long-standing health benefits. Gone are the days when union negotiations regularly produced improved benefits. Instead, unions now expend large amounts of energy just trying to hold on to benefits negotiated years ago.

Most union members are experiencing a decline in their health care coverage, not an improvement. Choice has suffered, and with it, a large measure of the control individuals have traditionally had over their health care. We have been forced to switch from an offensive strategy of improving benefits and coverage levels, to a defensive strategy of trying to hold on to the gains that we have won in the past.

One casualty of high health costs has been freedom of choice among physicians and other providers. As indemnity plans have become more expensive, workers have been forced to switch to HMO and PPO managed care plans. Further, employers often change health plans from year to year in an effort to negotiate better deals. This leads to a further restriction of choice as workers are forced to change plans and providers year after year.

Union members do not have uniformly unfavorable attitudes toward HMO's and PPO's. In the short run, managed care often allows unions to preserve benefits without increasing costs to the membership. But we also recognize that, in most cases, savings from managed care plans come from the discounted rates that those plans pay to providers. Providers make up the difference by shifting those costs onto other payers with less market power. Employer-by-employer efforts to contain costs don't work for long, as costs climb in other parts of the system. Only system-wide reform can bring costs under control and end the cost-shifting among payers.

A second, and even more significant, deterioration in health coverage is in regard to the affordability of coverage offered by employers. Over the past ten years, workers have had to pay an ever increasing share of their premiums, as well as higher deductibles, co-payments, and stop-loss amounts. A 1993 survey conducted by the Service Employees International Union (SEIU) of 400,000 of its members revealed some startling trends on cost-sharing. The sample included workers in both private and public employment in various industries.

The study found that the average share of the premium paid by the employee increased from 10.5% in 1987 to 18% in 1993. This means that the employee share of the total premium almost doubled over a six year period. Meanwhile, annual family premiums more than doubled over this six year period, from $2,599 in 1987 to $5,460 in 1993. Taken together this means that SEIU members with family coverage paid almost $1,000 a year, on average, in premium payments alone, up from $270 just six years ago. This is a significant amount for low and middle income workers. (The average wage in the study was under $29,000.)

Projecting this trend to the year 2,000 finds that the average SEIU member would pay 37 percent of the premium cost by that date—costs commonly predicted to be between $10,000 and $15,000. The study estimated that this would require some 30 percent of the after tax income of these workers.

While employee premium shares were rising at this astronomical rate, deductibles, co-payments, and stop-loss amounts were also increasing. For example, the average stop-loss, the amount a family is liable for before the plan begins paying at 100%, rose from $1,495 in 1989 to $4,188 in 1993. These cost-sharing increases are not unique to service workers and are being experienced by most of our AFL-CIO affiliates. In addition to the increasing share of after tax income that American workers are having to devote to health costs, monies formerly available for wage in-

crease are increasingly being used to finance the employer's increases in health premium contributions.

It's a rare local union leader, regardless of industry, that would say in 1994 that they've not had to trade one, two, or three percentage points in annual raises to stave off reductions in health benefits. A recent study by Lewin-ICF concluded that out of control health care costs over the decade of the eighties equated to a five percent cut in take-home pay of the average American worker in 1992.

The men and women of the AFL-CIO believe that the problem of the uninsured must be solved if we are to solve our health crisis. We also believe that the solution to the problem is to assure universal coverage, just as most of our counterpart countries in the industrialized world have already done. Finally, we believe that the route to universal coverage is a mandate on all employers to pay the lion's share of the health costs of their employees. If this option is rejected, we see only two alternatives—abandon the employment based system and in its place create a totally tax financed system, or abandon all hope of solving the current crisis.

The employer mandate is fundamental to this debate for one essential reason, because of political constraints, serious consideration is only being given to proposals that build on the employment based health system.

Opponents of the employer mandate claim that requiring all employers to pay for insurance will have an extreme negative effect on employment. The same arguments were made when minimum wage legislation was introduced. No significant employment effects resulted. The arguments were also made when Hawaii introduced its health reform legislation, mandating all employers to provide health insurance, yet employment in Hawaiian non-farm industries since then has skyrocketed.

Opponents of the employer mandate make the claim that mandate is too expensive and that we must build on the current health care system. We will commit over $1 trillion on health care this year alone.

THE EMPLOYER MANDATE IN THE HEALTH SECURITY ACT. (S. 1757)

The Health Security Act, builds on the strengths of the current system. It couples the employer mandate with an individual mandate, requiring everyone to join in the financing of the system. The Health Security Act protects workers and their employers from the possible effects of this requirement by capping how much businesses and individuals will have to pay.

When the factors of cost containment and shared financial responsibility take hold, businesses will benefit. The Congressional Budget Office released its analysis of the Administration's Health Proposal on Tuesday and revealed that "the total cost that all businesses together would pay for health insurance for active workers would be about $20 billion less in the year 2000 if the proposal were implemented that if the current system were to continue unchanged." This does not factor the additional $15 billion saved by businesses because of the early retiree provision. And for working men and women, the CBO study reveals that reductions in cost would reach over $90 billion in 2004.

SECURITY AND CHOICE

The Health Security Act, unlike other proposals under consideration, would offer working men and women true security and portability, guaranteeing that their doctors will not change and their bills will get paid—even if they are unemployed.

Opponents of reform have suggested that the Health Security Act would limit individuals choice of plans. This is untrue. By our estimates, workers will see an expanded choice of providers because today, a worker's only choice of plans is limited by what is being offered by employers. In fact, between the years 1988 and 1993, the number of workers allowed to choose a fee-for-service plan dropped from 89 percent to 65 percent. ["1992 Health Care Benefits Survey," Foster Higgins, 1992; "Health Benefits in 1993," KPMG Peat Marwick]

COST CONTAINMENT

The Health Security Act, unlike other proposals under consideration, offers real cost containment. Considering we have added an additional $100 billion dollars to our health care spending over each of the past 4 years, we can not afford to let our spending go unchecked. The managed competition approach proposes to hold costs down to the rate of inflation in the CPI by the year 2000 but offers *no* explanation on how it will accomplish this. The Health Security Act, through administrative simplification, preventive care, increased purchasing clout of consumers, a cap on premium increases and an employer mandate *will* hold the rate of increase to the CPI by the year 1999.

Tuesday's CBO study found that "over time . . . the combined effects of lowering the rate of growth of health insurance premiums and the cuts in the Medicare program would dominate (over initial cost increases). Thus, the CBO projects that national health expenditures would fall $30 billion below the current CBO baseline by calendar year 2000, and would be $150 billion below that baseline in 2004."

For these and other reasons, the AFL-CIO is supporting the Health Security Act of 1993.

PREPARED STATEMENT OF PHYLLIS TORDA

Mr. Chairman and Members of the Committee: Good morning. Thank you for allowing me to testify before you today. Families USA is a national nonprofit organization that represents consumers on health and long term care issues. The topic of this hearing today is on the uninsured. We believe that the current crisis state of Americans loosing and lacking health care coverage can and must be fixed. We strongly support the President's goal, and his specific proposal, to achieve universal and comprehensive coverage for all Americans. I will focus my testimony today on why an employer mandate is the most effective and practical way to achieve universal coverage. I have attached to my testimony our most recent report which analyzes the impact of three prominent bills which are before this committee on ten American families. I hope you find it informative.

IS THERE A HEALTH CARE CRISIS?: MILLIONS ARE LOSING HEALTH INSURANCE

The goal of health care reform must be to assure every person in America that he or she will never lose his or her health insurance, no matter what. Attached is a copy of a report we released earlier this year that found that over 2.25 million people lose their health insurance each month. In the state of New York, for example, 130,000 people lose their health insurance each month. Most of the people who lose their coverage will lack insurance for less than five months, yet a significant portion will lack insurance for six months or more. During this time, families are at grave financial risk if a member becomes sick or injured. Over the course of a year, nearly one out of every four Americans lose or lack health insurance for part of the year.

People lose their health insurance for a variety of reasons. Many people, for example, lose their coverage because they lose their jobs, their employer's policy is canceled, or they change jobs. While most of them regain coverage in the future, some never regain their coverage and others will be subject to limitations on coverage for pre-existing conditions.

American families with a member who has chronic health condition can easily find themselves in the position of being unable to change jobs because the family is dependent on the health insurance obtained through one family member's job. One in five (19%) workers report that they or a family member are locked in their jobs because new work offers limited or no health insurance.

ACHIEVING UNIVERSAL COVERAGE

We believe that no one should lose or lack high-quality health care coverage. Health security must be assured for all Americans. Several alternatives to reform the health care system have been proposed by Members of Congress. They do not all reach the goal of universal coverage. Three basic approaches could result in universal coverage: an individual mandate, a single payor system, and an employer mandate.

Families USA has concluded that the best way to reach universal coverage is through an employer mandate. Compared to all other solutions, an employer mandate builds on our employer-based insurance system and would be the least disruptive. It would level the playing field among different employers, most of whom provide such coverage today. It would also eliminate the large, unpredictable and inequitable cost shifts that employers bear today for the uninsured workers of other employers. It is a practical and fair way to achieve our goal.

I would like to further explain why an employer mandate is the best solution for our current crisis.

THE STATUS QUO

Today, most businesses provide insurance for their employees. Yet, small business owners, employees and their families encounter great difficulties obtaining affordable health insurance.

Small groups generally must pay ten to forty percent more for health insurance than large groups. Those who would purchase health insurance as individuals or as part of a small business group face another formidable barrier to health coverage because of medical underwriting practices. Medical underwriting is the process by which an insurer evaluates the health history and the potential for poor health status and high claims for an individual or group. Based on current underwriting practices, approximately 15 percent of all small businesses are ineligible for insurance or eligible only for restricted coverage.

Some Members argue that changing the rules by which businesses purchase coverage is sufficient reform. In 1992, we prepared a study of insurance market reforms that concluded that changes in insurance company rules, in isolation, would mean that many more businesses would see their premiums rise as would see their premiums go down. Market reforms only might result in increased access for some minority of people who are without coverage but the premiums for most businesses would continue to soar and even be exacerbated. The major problems of eliminating the extra costs for uncompensated care and out of control premiums would continue unabated for all businesses and millions of people would continue to lack coverage. While we agree that health care reform must change the rules by which insurance companies operate, insurance reform without comprehensive reform will not work.

INDIVIDUAL MANDATE

One way, in theory, to reach the goal of universal coverage is the individual mandate. Under this scheme, all individuals, not employers, are required to purchase their own health insurance. Employers could be required to offer coverage, but would not be required to pay for any part of the premium.

But, can coverage under this scheme be affordable? In order to make coverage affordable for individuals significant subsidies would have to accompany such a mandate. We know that most businesses that do not provide coverage are small businesses, many with low-wage workers. Without employers contributing a portion of the premium cost, the entire burden becomes the individual's. These are the individuals that can least afford to pay the entire premium for coverage. For example, a worker making $12,000 a year would have to pay a quarter to a third of his entire income for health insurance. Without an employer contribution, in order to make the coverage affordable, taxpayers will have to foot the entire cost of adequate subsidies.

Additionally, employers that now provide financial help for coverage may decide to drop their contribution if federal subsidies are available for individuals. This would, in turn, increase the total funds needed to make the individual mandate affordable.

Federal government costs would also increase as a result of increased administrative responsibilities. An individual mandate would necessitate an enlarged bureaucracy to keep track of each individual's coverage status.

Given the current budget constraints this country faces, an individual mandate would create a significant financial burden that the taxpayers and Congress are not likely to embrace.

SINGLE PAYOR

A single payor, Canadian-style system has been touted by many as the most simple, straightforward approach to ensuring universal coverage. For Canadians to receive care, they must present their national card to doctors, who bill their provincial governments; the provinces fund hospitals directly under set budgets. All this is paid for from significant provincial and federal revenues collected from citizens and employers.

Clearly, the goal of providing health security for all Americans would be reached if this model were enacted in this country. The political, as opposed to the substantive, practicality of this approach, however, is questionable. The wholesale redistributional changes, as well as the need for unpopular tax increases makes the tax-financed option less politically viable.

EMPLOYER AND EMPLOYEE MANDATE

It is clear that an employer mandate which requires all employers and employees to contribute toward their coverage is a fair and practical way to reach the goal of universal coverage.

The reasons we support an employer mandate are as follows:

- It is the alternative that is least disruptive to the current system. Since most employers now provide coverage, an employer mandate would help fill in the

gaps for working families. It would not unravel a system that does work for many Americans.

- It levels the playing field. Most employers are contributing toward their employees' coverage now. Additionally, many employers are paying for the coverage of working spouses whose employers do not want to pay their fair share. Employers who pay for coverage also foot the bill for uncompensated care of those people who are uninsured and who have jobs that do not provide coverage.
- It requires a smaller tax burden than either an individual mandate which leaves the whole burden of the cost on the individual and the taxpayers or the single payor model which requires massive changes in the collection and distribution of tax dollars.
- Recent polling seems to indicate that Americans are comfortable with building on the current employer-based system by imposing an employer mandate.

We recognize that some employers and employees will need subsidies to help meet their financial obligations. Small businesses and low-income individuals specifically will need such assistance. The federal government, we believe, should provide these subsidies, which would total far less than under an individual mandate.

A frequently heard criticism that is made of the employer mandate is that jobs will be lost if this system is imposed. Yet, under the President's health reform bill, significant subsidies are given to small businesses (and individuals) that will need financial assistance to meet their obligations. For the worker that makes $12,000, for example, the employer contribution equals a $.20 and hour increase. Increases in the minimum wage at even higher levels have never produced the doom and gloom scenarios of job lose that were predicted. Moreover, for the businesses that already pay for health care coverage, they will receive relief because they no longer will need to subsidize the costs of uncompensated care.

CONCLUSION

This year we must enact comprehensive health care reform that will guarantee that families will never lose their health insurance. The goal is within our reach. Requiring employers and employees to contribute to coverage can get us to that goal. We look forward to working with you as we complete this task.

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Losing Health Insurance

Every month more than two million Americans lose their health insurance, and millions more lie awake at night worrying that they might be next. During any period of time Americans must go without health insurance, they are in a position similar to skidding on an icy mountain road. It may be over quickly. They will probably survive it, but their family may go over the cliff.

Tom L. suffered a heart attack while he was between jobs. His surgery left him with a $25,000 bill to pay out-of-pocket.

Kathleen and Don N. lost their health insurance when Don lost his job. Shortly thereafter, Kathleen was diagnosed with cancer. To pay for her cancer treatment, they ultimately had to sell their house and move to a small apartment.

This Families USA special report presents the first state-by-state estimates of the number of Americans who each month lose their health insurance and the peace of mind that they will able to take care of their families' health care needs.

♦ Nationally, 2.25 million Americans a month lose their health insurance.

♦ The following states have the largest numbers of persons who lose their insurance each month:

California (306,000)	Michigan (76,000)
Texas (173,000)	North Carolina (64,000)
New York (130,000)	Georgia (62,000)
Florida (113,000)	Virginia (55,000)
Illinois (90,000)	Louisiana (51,000)
Ohio (89,000)	Massachusetts (50,000)
Pennsylvania (89,000)	

Why Do Americans Lose Their Health Insurance?

Americans lose their health insurance each month for a variety of reasons. Many are laid off from their jobs or have a spouse or parent who is laid off. They either cannot afford to continue paying their full health insurance premiums on their own, or are no longer eligible to do so.

Ms. H. is a laid off computer technician. To continue paying for health insurance for herself and two children would have cost her $500 a month which, without a job, she could not afford.

Other Americans lose their health insurance when they change jobs. This can happen because many jobs require a waiting period before new employees are eligible for health benefits.

Mrs. S.'s husband recently lost his job at AT&T. They cannot afford the $464 a month it would cost to maintain their health insurance through AT&T. Mrs. S. is a nurse and can only get insurance through the hospital for which she works beginning January 1, 1994. Mrs. S. has had meningitis twice and is afraid that, if it recurs during the period when they are without insurance, her family will be destroyed financially.

Often new coverage excludes preexisting health conditions, leaving individuals unprotected for those health problems for which they are most likely to need health insurance.

Larry P. injured his knee at home and required surgery to remove bone fragments and almost

all of the cartilage in his knee. When he left his job that required heavy lifting and took a new job at a video store, his new health insurance did not cover his knee.

Many Americans who are self-employed or work in small businesses lose their insurance when they can no longer afford the high premiums insurance companies charge individuals and small groups.

Patricia P., a self-employed office worker, was paying $9,000 a year for a major medical policy with a $1,000 deductible. This policy was her largest single expense, more than her mortgage. She had to drop her coverage.

Mrs. A. and her husband run a plumbing business. They had to drop their insurance when premiums increased from $350 a month to $550 a month.

Americans lose their health insurance when insurance companies take advantage of fine print to cancel coverage for those who need insurance the most—those who develop a serious health condition.

Dr. S. is a dentist. For 15 years he paid premiums for himself and his family. When he developed cancer, the insurance company first raised his premium from $2,650 to $10,000 a year, and then canceled the policy.

Jean and Tom M. own a small grocery store in rural Tennessee. For eight years they paid their health insurance premiums. When Tom developed cancer, the insurance company canceled his policy because "they were no longer profitable.

In other cases, insurance companies raise health insurance premiums for those with a serious health problem to the point where the insurance becomes unaffordable for individuals and for entire groups.

Mrs. B. needed angioplasty. Six months later her health insurance premiums went from $215 a month to $1,700. She had to drop her coverage.

Sometimes individuals lose their health insurance when insurance companies go bankrupt.

Nancy and Marshall M. paid $500 a month for their insurance coverage, which had been recommended by Marshall's professional organization. In January of 1991, they had twins and one needed neonatal care because of a heart problem. Their insurance company was insolvent and did not pay their $100,000 bill. They now have a collection agency breathing down their necks.

Among the Americans most likely to lose their health insurance are those who have graduated from college and are no longer eligible for coverage through their parents' policies.

A[illegible]a P. graduated from college in 1990. She came from Los Angeles to Washington D.C. to find a job. She was covered by her mother's policy until she turned 25. Now she has two jobs, neither of which offers health insurance. Her husband's job provides insurance that covers him, but it would cost them $300 a month to cover her. As a young family, they cannot afford that expense.

Number of Persons Losing Healt.· Insurance Each Month By State, 1993

State	Average Number of Persons Losing Health Insurance Each Month
United States	2,255,000
Alabama	36,000
Alaska	6,000
Arizona	41,000
Arkansas	30,000
California	306,000
Colorado	41,000
Connecticut	23,000
Delaware	6,000
District of Columbia	6,000
Florida	113,000
Georgia	62,000
Hawaii	11,000
Idaho	13,000
Illinois	90,000
Indiana	44,000
Iowa	23,000
Kansas	20,000
Kentucky	32,000
Louisiana	51,000
Maine	11,000
Maryland	43,000
Massachusetts	50,000
Michigan	76,000
Minnesota	36,000
Mississippi	28,000
Missouri	43,000
Montana	12,000
Nebraska	14,000
Nevada	15,000
New Hampshire	9,000
New Jersey	46,000
New Mexico	21,000
New York	130,000
North Carolina	64,000
North Dakota	6,000
Ohio	89,000
Oklahoma	32,000
Oregon	27,000
Pennsylvania	89,000
Rhode Island	8,000
South Carolina	33,000
South Dakota	6,000
Tennessee	45,000
Texas	173,000
Utah	24,000
Vermont	5,000
Virginia	55,000
Washington	49,000
West Virginia	18,000
Wisconsin	36,000
Wyoming	6,000

SOURCE. Lewin-VHI estimates based on the 1990 Survey of Income and Program Participation, the 1987 National Medical Expenditure Survey and four years of pooled March Current Population Survey data.

Estimating the Number of Americans Losing Health Insurance

The estimates in this special report are based primarily on data from the 1990 Survey of Income and Program Participation (SIPP). The SIPP was conducted by the Bureau of the Census and contains the most extensive information to date about families' health insurance coverage on a month-by-month basis. The 65,369 persons interviewed as part of the SIPP represent the civilian, non-institutionalized population of the United States.

In order to update the estimates from the 1990 SIPP to 1993, Bureau of the Census estimates of the change in the population from 1990 to 1993 were used.

The state-by-state estimates are based on state-level estimates of the distribution of persons with health insurance for part of the year. These state-level estimates are based on a dataset that matched four years of the most recent March Current Population Survey (CPS) data to data from the 1987 National Medical Expenditure Survey (NMES). Due to the sampling frame and size of the pooled samples, the CPS data allow for state-level estimates.

The SIPP data allow examination of the number of persons losing health insurance of any kind, including private, Medicaid and other public insurance. Approximately 79 percent of all persons who lose their insurance were covered previously by private insurance.

Who Loses Health Insurance?

This special report focuses on the more than two million Americans who lose their health insurance each month. These Americans are likely to be without insurance for less than a year and have some distinctive demographic characteristics.

Based on data collected 1983 to 1986, half (48%) of those who lost insurance lacked health insurance for five months or less; 16 percent lacked insurance for six to nine months; and eight percent lacked health insurance for 10 to 13 months.[1]

Based on 1987 data, 29 percent of those who lacked health insurance for part of the year lacked insurance for four months or less. Another 39 percent of those who lacked health insurance for part of the year lacked insurance for five to eight months. For those having private insurance for part of the year in 1987, one-third (34%) lacked insurance for four months or less. Another 38 percent of those who lost their private health insurance for part of the year lacked insurance for five to eight months.[2]

Based on the 1990 SIPP data, Americans who lose their health insurance have some distinctive demographic characteristics. Over one-third (36%) were full-time workers in the month before losing their insurance; almost one-third (30%) had family incomes of $30,000 or more; and over one-fourth (27%) had at least some college education. Almost one-third (29%) of those who lost their insurance were under age 18. Sixteen percent of those who lost their insurance worked in professional and related services and 14 percent worked in manufacturing in the month prior to losing their insurance. These demographic groups are more highly represented among those who lost their insurance at some point during the year than among those who lacked insurance for the entire year.[3]

Other research has focussed on the demographic characteristics of those who lose their health insurance and are likely to experience relatively short periods without health insurance. This research shows that those who lose their health insurance for relatively short periods of time have the following characteristics immediately before losing their health insurance: annual family income above $29,500; a high school diploma or higher educational level; and employment in a number of industrial sectors (manufacturing, trade, utilities, finance/ insurance/real estate, business services and professional services). Other characteristics of those who lose their health insurance for relatively short periods are: working full-time in the month prior to losing insurance and in the month of losing insurance; being between the ages of 18 and 24; living in the Northeast; and being married.[4]

Conclusion

More than two million Americans lose their health insurance each month. These Americans are likely to lack insurance for significantly less than a year. But, as many Americans have experienced, a period without health insurance, no matter how brief, can lead to financial catastrophe.

Americans who lose their health insurance suffer long-term consequences. When they gain new insurance coverage, that coverage is likely to exclude coverage for preexisting health conditions, the very conditions for which they are most likely to need insurance.

Endnotes

1. Katherine Swartz, John Marcotte and Timothy McBride, "Spells Without Health Insurance: The Distribution of Durations When Left-Censored Spells Are Included," *Inquiry* vol. 30, (Spring 1993), pp. 77-83.

2. Kathleen Short, *Health Insurance Coverage: 1987-1990*, U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Household Economic Studies, Series P-70, n. 29, (Washington, D.C.: Government Printing Office, 1992).

3. Lewin-VHI analysis of the 1990 Survey of Income and Program Participation.

4. Katherine Swartz, John Marcotte and Timothy McBride, "Personal Characteristics and Spells Without Health Insurance," *Inquiry* vol. 30, (Spring 1993), pp. 64-68.

PEOPLE WHO WILL LOSE THEIR INSURANCE

Over two million Americans lose their health insurance each month.[1] Most of these people will lack insurance for less than five months, yet a significant portion will lack insurance for six months or more.[2] During this time, families are at grave financial risk if a member becomes sick or injured.

Jerry and Donna Weldon live in Fenton, Missouri with their two young children. Jerry is a plumber and the family is covered through Jerry's union. Every three months, Jerry must work a minimum number of hours in order to qualify for health insurance coverage. Lately, work has been slow and the number of hours required by the union for health insurance will be increasing. The Weldons' eight-year-old son has leukemia and he had a bone marrow transplant this fall. After this procedure, he will need ongoing medical care and prescription drugs. The Weldons are worried that they will lose their insurance in the future because of Jerry's lack of work and the increasing number of required hours for insurance.

CLINTON:

The Weldons would always have the same comprehensive insurance, regardless of how much work Jerry gets.

As of 1998, the Clinton bill would guarantee that no American would lose their health insurance, regardless of any changes in health, employment or economic status.

Workers and their families would receive insurance coverage through their employment. Self-employed or unemployed people and their families would purchase coverage directly. Their insurance premiums would be fully tax deductible, instead of only 25 percent deductible as they are now. Discounts would help businesses and families afford their premiums.

Families would choose from a variety of health plans offered by regional health alliances where they live. Employees of firms with more than 5,000 employees could choose from at least three plans offered by their firm.

COOPER:

The Weldons would still have to worry about losing health insurance.

Under the Cooper bill, all individuals, families and small businesses that *choose* to purchase health insurance would do so through their local cooperative. Employers would choose to contribute or not contribute to their employees' health insurance premiums, as they do now.

Employees and their families could still lose their health insurance if they lost their job; if they changed jobs; if their employer could no longer afford the premiums; if they retired before age 65; and for a variety of other reasons.

Low-income families and individuals who choose to purchase insurance would be eligible for some financial assistance.

Families and individuals who purchase insurance on their own could deduct from their taxes the premium for the lowest-priced plan.

CHAFEE:

The Weldons would have to worry about losing health insurance at least until the year 2005, and possibly longer.

Under the Chafee bill, all individuals, families and small businesses could choose to purchase insurance through a number of local purchasing groups or on their own. Employers would choose to continue to contribute or not contribute to their employees' health insurance premiums, as they do now.

In the year 2005, this bill would require all individuals and families to purchase insurance. This individual mandate would go into effect *only if* federal Medicare and Medicaid savings at that time are sufficient to finance premium assistance for individuals and families with incomes up to 240 percent of poverty.

Families and individuals who purchase insurance on their own could deduct the premium from their taxes, up to the average cost of the lowest-priced one-half of plans.

At least until the year 2005, and possibly longer, employees and their families could still lose their health insurance if they lost their job; if they changed jobs; if their employer could no longer afford the premiums; if they retired before age 65; and for a variety of other reasons.

1. Families USA Foundation, *Losing Health Insurance* (Washington, D.C.: Families USA Foundation, 1993).

2. Katherine Swartz, John Marcotte and Timothy McBride, "Spells Without Health Insurance: The Distribution of Durations When Left-Censored Spells are Included," *Inquiry* vol. 30, (Spring 1993), pp. 77-83.

INADEQUATE INSURANCE

Millions of Americans have inadequate insurance that can leave them with thousands of dollars in medical bills. Such inadequate coverage is most common for families who buy non-group coverage and can only afford or qualify for very limited coverage with high deductibles, high copayments or limitations in benefits. Families USA estimates that 18 million Americans who have insurance are currently spending ten percent or more of their pretax income on out-of-pocket health expenses, excluding expenses for nursing home care, health insurance premiums, Medicare payroll taxes, federal, state and local taxes, and wages lost because of their employers' costs for health insurance.[1] Economists generally consider individuals to be underinsured if they are at risk of spending ten percent or more of their income on out-of-pocket health costs.[2]

> *Susan and David Mast live in Wheaton, Maryland with their three young children. David Mast is a self-employed contractor. In 1992, his income was about $20,000. He paid $4,000 to purchase health insurance on his own for his family, but couldn't afford the extra $4,000 a year maternity coverage would have cost. Even then, the coverage wouldn't have been effective for one year. Their son, Joshua, was born in February 1992. Susan Mast worked two jobs as a proofreader and typesetter and took in babysitting and accounting work to pay off the $3,300 bill from that birth.*

CLINTON:

The Mast family would have a choice of health insurance plans that provide comprehensive benefits, and would save about $2,000 a year in premium costs.

The Clinton bill specifies a comprehensive benefit package that would cover a full range of services.

The guaranteed national benefits have no lifetime limitations on coverage and would include: hospital services; emergency services; services of physicians and other health professionals; mental health and substance abuse services; family planning services; pregnancy-related services; hospice care; home health care; extended-care services; ambulance services; outpatient laboratory and diagnostic services;

COOPER:

Would not guarantee the Mast family comprehensive health benefits.

The Cooper bill would require all health plans to provide a uniform set of effective benefits, but the bill fails to specify what benefits would be covered within the broad categories of medically appropriate treatments, the full range of effective clinical preventive services and a full range of diagnostic services. The bill does not specify limits on the amount families would have to pay in deductibles and copayments. The bill leaves these decisions to a Health Care Standards Commission and then to the Congress.

CHAFEE:

Would not guarantee the Mast family comprehensive health benefits.

The Chafee bill would require all health plans to provide a standard benefits package. The bill includes the following guidelines: medical and surgical services; prescription drugs; preventive services; medical equipment; rehabilitation and home health care after an acute care episode; severe mental illness services and substance abuse services; hospice care and emergency transportation services.

The guidelines do not specify annual limits on the amount families would have to pay for deductibles and copayments.

outpatient prescription drugs and biologicals; outpatient rehabilitation services; durable medical equipment, prosthetic and orthotic devices; vision and hearing care; dental services; and health education classes.

A variety of preventive services would be available at no cost. Prescription drug, dental, vision and mental illness services would be more generous than many plans today.

No individual would have to spend more than $1,500 annually for covered services and no family would have to spend more than $3,000 annually.

Based on national average premiums, the Mast family would pay approximately $2,000 for health insurance, and that amount would be fully tax deductible.

The Health Care Standards Commission and the Congress could review annually the uniform set of effective benefits. Thus, benefits could be modified or eliminated every year.

Because their family income is under 200 percent of poverty, the Mast family would be eligible for some assistance to cover the cost of their premium. Given their income, the Masts would have to pay about 19 percent of the premium for the lowest-priced plan, and that amount would be tax deductible.

Since the Cooper bill does not specify a benefit package, it is impossible to determine the amount the Mast family would have to pay for premiums, deductibles, copayments and uncovered services.

Under this bill, a Benefits Commission would recommend a standard benefits package for approval by the Congress. The Commission could eliminate any of the categories of proposed covered items and services. This benefits package could be reviewed annually by the Benefits Commission and the Congress. Thus, benefits could be modified or eliminated every year.

Alternatively, health plans could offer a catastrophic benefit package that would cover the same services, but require very high deductibles and copayments. These plans would leave most families with high uncovered health costs.

Furthermore, families and businesses would have to pay taxes on any benefits that are not included in the standard benefits package and on insurance premiums that are higher than the average of the lowest-priced one-half of plans.

Because their family income is under 240 percent of poverty, the Mast family might be eligible for some assistance to cover the average cost of the lowest-priced one-half of plans offered in the area. Such assistance would be available only if the federal government realizes sufficient savings in the Medicaid and Medicare programs to fund the premium assistance.

If assistance becomes available, beginning in 1999, the Masts would have to pay about 13 percent of the premium, and that amount would be tax deductible, up to the average cost of the lowest-priced one-half of plans.

Since the Chafee bill includes only guidelines for the standard benefits package, it is impossible to determine the amount the Mast family would have to pay for premiums, deductibles, copayments and uncovered services.

1. Families USA Foundation, *Half of Us: Families Priced Out of Health Protection* (Washington, D.C.: Families USA Foundation, 1993).

2. Pamela J. Farley, "Who Are the Underinsured?" *Milbank Memorial Fund Quarterly/Health and Society* vol. 63, no. 63, (1985), pp. 477-501.

EARLY RETIREES LOSING HEALTH BENEFITS

One-third (32%) of all retirees who have health insurance coverage through their former employers are under age 65.[1] In light of skyrocketing health care costs and new accounting rules requiring employers to report this liability, companies are cutting health benefits for current and future retirees. A recent major survey of larger corporations found that 12 percent of companies responding have eliminated or plan to eliminate all retiree health benefits. Another 56 percent have reduced or plan to reduce health benefits covered.[2]

Kazimer "Casey" Patelski and his wife Bonnie live in Costa Mesa, California. Casey was a design engineer for McDonnell Douglas for 28 years. He helped design various aircraft, missiles, satellites and the Skylab Space Station. Casey, who suffered from polio as a young man, turned down numerous job offers from other companies over the years because of the generous retirement benefits, including health insurance, promised by McDonnell Douglas. When Casey retired at age 63, he was assured that he and Bonnie would have health insurance coverage for the rest of their lives. A year later, McDonnell Douglas announced that it was eliminating health insurance benefits for all retirees. Current retirees, like the Patelskis, were allowed to purchase health insurance coverage with their pension funds.

CLINTON:

The federal government would pay 80 percent of the Patelskis' health insurance premiums until Mr. Patelski was eligible for Medicare.

The Clinton bill would provide early retirees and their families with guaranteed health coverage. Under this bill, the federal government would pay 80 percent of premiums for retirees between the ages of 55 and 65. For retirees whose previous employers currently pay retiree health costs, their employers would now pay the retirees' share of premiums (20 percent).

COOPER:

The Patelskis would still have to pay 100 percent of their health insurance premiums.

The Cooper bill would provide no federal assistance for early retirees who are not yet eligible for Medicare, or their families.

If the Patelskis choose to buy insurance, under this bill they would buy that insurance through their local purchasing cooperative. Their premiums would probably be less than if they had to buy insurance on their own, but they could pay higher premiums than others in the purchasing cooperative because of their age.

CHAFEE:

The Patelskis would still have to pay 100 percent of their health insurance premiums.

The Chafee bill would provide no federal assistance for early retirees who are not yet eligible for Medicare, or their families.

If the Patelskis buy insurance under this bill, they could choose to purchase it through a number of local purchasing groups or on their own. Their premiums might be somewhat less than what they would pay currently, but they would pay higher premiums than others in their area because of their age.

1. Steven DiCarlo, Jon Gabel, Gregory de Lissovoy and Judith Kasper, *Research Bulletin: Facing Up to Postretirement Health Benefits* (Washington, D.C.: Heath Insurance Association of America, 1989).

2. Hewitt Associates, *FASB Retiree Health Accounting* (Lincolnshire, IL: Hewitt Associates, October 1993).

SMALL BUSINESS OWNERS AND THEIR FAMILIES

Small business owners, employees and their families encounter great difficulties obtaining affordable health insurance. Small groups generally must pay ten to 40 percent more for health insurance than large groups. Those who would purchase health insurance as individuals or as part of a small business group face another formidable barrier to health coverage—medical underwriting practices. Medical underwriting is the process by which an insurer evaluates the health history and the potential for poor health status, and high claims, for an individual or group. Based on current underwriting practices, approximately 15 percent of all small businesses are ineligible for insurance or eligible only for restricted coverage.[1]

Ann and Hubert Maddux live in Corpus Christi, Texas with their four-year-old daughter and infant son. Hubert runs a tackle shop and makes approximately $25,000 a year. As a small business owner, the best insurance Hubert could get for himself and his family was through his alma mater in 1986. At that time his premiums were $1,000 a year. After their daughter was born with Downs Syndrome and serious heart defects, the Maddux family's premiums increased to $17,000 annually. For the last two years, the Madduxes have cut back on their insurance coverage because of the high costs. As of January 1994, the Madduxes pay $8,520 a year for their insurance. But the policy requires a $5,000 deductible per person, and payment of half of the first $10,000 in covered expenses per person. Both children need prescription drugs which the family's insurance does not cover. Medicine for the children costs the family between $100 and $200 per month.

CLINTON:

The Maddux family would save about $5,700 on health insurance premiums and would have a choice of plans that provide comprehensive benefits. They would have to spend no more than $3,000 out of pocket annually for their family's health care.

Under the Clinton bill, most Americans would obtain their insurance through consumer-controlled regional health alliances. This pooling of individuals and businesses would result

COOPER:

The amount the Maddux family would pay for premiums and the coverage they would have, including deductibles and copayments, are unknown.

Under the Cooper bill, the Maddux family and other small businesses and individuals who choose to purchase health insurance would purchase it through their local purchasing cooperative. Since not all small

CHAFEE:

The amount the Maddux family would pay for premiums and the coverage they would have, including deductibles and copayments, are unknown.

Under the Chafee bill, the Maddux family and all others who purchase health insurance could purchase it through a number of local purchasing groups or on their own. Each

in lower premiums for those who previously purchased insurance alone as small businesses or individuals. The Maddux family would pay the same premium as all others under age 65 purchasing insurance through the alliance.

Small businesses and individuals would no longer see their premiums skyrocket from year to year. This bill would limit the amount by which insurance companies can raise premiums each year so that, by the end of the decade, premiums would go up no faster than inflation.

Insurers would no longer be able to set the premiums for small businesses on the basis of that group alone. Instead, premiums would be based on health costs for the entire region. Insurers would no longer be able to reject businesses or individuals for any reason.

Small businesses would be eligible for significant federal discounts on premiums. No business would have to spend more than 7.9 percent of its payroll for health insurance costs. Businesses with 75 or fewer employees would pay less if their average wages are $24,000 or less. The lowest wage small businesses would pay only 3.5 percent of payroll.

Many small business owners would pay less to cover themselves, their families and their employees than they now pay just to cover themselves and their families. Based on national average premiums, the Maddux family, for example, would pay no more than about $2,800 for health insurance premiums. This amount would be fully tax deductible. The amount the Madduxes currently pay for health insurance would cover the cost for the Maddux family and two additional families under the Clinton bill.

businesses and individuals would choose to purchase insurance, the purchasing cooperatives would not pool as much risk or have as much negotiating power as if all small businesses and individuals had to purchase insurance through the cooperative.

The Maddux family's premiums would differ from others who purchase insurance through the cooperative based on their age. Any plan that denied coverage to any person, family or group because of one person's health condition would not be tax deductible.

This bill does not specify the standard benefits, or the deductibles and copayments.

Small businesses and families could deduct the cost of their health insurance premiums, up to the cost of the lowest-priced plan, and only for the benefits included in the unspecified uniform set of benefits. Small businesses would not receive any discounts on premiums for low-wage workers, nor would there be a cap on the percentage of payroll spent for premiums.

There are no limits on the amount premiums could increase each year.

Since this bill provides no subsidies for small businesses, small business owners and their families would be eligible only for individual subsidies. Families and individuals with incomes under 100 percent of poverty would be fully subsidized for the cost of the lowest-priced plan and would pay ten percent of the difference between the cost of the lowest-priced plan and higher-priced plans. Families and individuals with incomes between 100 percent and 200 percent of poverty would pay the percentage of their income that is above the poverty line for the lowest-priced plan and that same percentage of the difference between the cost of the lowest-priced plan and higher-priced plans.

Since the Maddux family's income is 74 percent above the poverty line, they would pay 74 percent of the cost of the premium for the lowest-priced plan. This amount would be tax deductible.

Since the Cooper bill does not specify a standard benefits package, it is impossible to determine the amount the Maddux family would pay for premiums, deductibles, copayments and uncovered services.

purchasing group would therefore not pool as much risk or have the same negotiating power as if everyone in a region purchased insurance through one group.

The Maddux family's premiums would differ from others in their area based on how they purchase their insurance and on their age. Plans could not deny coverage to any person, family or group because of one person's health condition.

This bill provides guidelines for a Benefits Commission to use in recommending a standard benefits package to Congress, but the bill does not specify the amount families and individuals would have to pay in deductibles and copayments.

Small business owners and their families could deduct the cost of their health insurance premiums, up to the average cost of the lowest-priced one-half of health plans offered in the area. Small businesses would not receive any discounts on premiums for low-wage workers, nor would there be a cap on the percentage of payroll spent for premiums.

There are no limits on the amount premiums could increase each year.

Since this bill provides no subsidies for small businesses, small business owners and their families would be eligible only for individual subsidies. If federal Medicare and Medicaid savings are sufficient to fund premium assistance, this bill would phase in assistance for families and individuals with incomes up to 240 percent of poverty, from 1997 to 2005.

If such assistance becomes available, as of 2002 the Maddux family would pay about 53 percent of the cost of the average of the lowest-priced one-half of plans offered in the area. This amount would be tax deductible.

Since this bill includes only guidelines for the standard benefits package, it is impossible to determine the amount the Maddux family would pay for the premiums, deductibles, copayments and uncovered services.

1. Wendy Zellers, Catherine McLaughlin and Kevin Frick, "Small Business Health Insurance: Only The Healthy Need Apply," *Health Affairs* vol. 11, no. 1, (Spring 1992), pp. 174-180.

EMPLOYEES VULNERABLE TO ARBITRARY LIMITS ON BENEFITS

Approximately 40 percent of all employees and their families are covered by employer health plans that are self-insured.[1] Self-insured companies do not purchase health insurance from a private insurance company. Instead, they pay the cost of their employees' medical care directly. The U.S. Supreme Court recently ruled that self-insured employers may limit or eliminate health insurance benefits at any time, even after an employee or a family member contracts a serious illness.

John and Joan Cleveland of St. Louis, Missouri had health insurance through Joan's employer, a company that is self-insured. John was diagnosed with leukemia in September 1990, and he needed a bone marrow transplant. Even though his insurance had a $500,000 lifetime maximum, the policy capped coverage of organ and tissue transplants at $75,000. John's transplant cost about $250,000. John died of complications from his transplant in June 1993.

CLINTON:

John and Joan Cleveland would have had to pay no more than $3,000 out of pocket for John's medical care in the year that he had his bone marrow transplant.

The Clinton bill would prohibit all employers and insurers from imposing caps or exclusions on coverage for specific medical conditions or any lifetime limit on benefits for covered services. The bill would require all businesses, whether they pay for their employees through a regional health alliance or through their own corporate alliance, to provide the comprehensive benefits specified by federal law. John Cleveland's bone marrow transplant would have been covered.

COOPER:

Joan Cleveland's employer could not impose arbitrary limits on the Clevelands' health benefits, but it is impossible to know if John's bone marrow transplant would have been covered. It is impossible to determine the amount the Clevelands would have had to pay out of pocket for John's medical care.

The Cooper bill would prohibit all employers who provide insurance, either through a purchasing cooperative or on their own, from limiting any benefits in the uniform set of benefits.

The bill, however, does not specify the uniform set of effective benefits within the broad categories of medically appropriate treatments, clinical preventive services and diagnostic services. The bill also does not specify the amount families would have to pay in deductibles and copayments. The uniform set of benefits could include limits on benefits for specific treatments or diseases. The bill leaves these decisions to a Health Care Standards Commission and then to the Congress.

The Health Care Standards Commission and the Congress could review annually the uniform set of benefits. Thus, benefits could be modified or eliminated every year.

CHAFEE:

Joan Cleveland's employer could not impose arbitrary limits on the Clevelands' health benefits, but it is impossible to know if John's bone marrow transplant would have been covered. It is impossible to determine the amount the Clevelands would have had to pay out of pocket for John's medical care.

The Chafee bill would prohibit all employers who provide insurance, either through a purchasing group or on their own, from limiting any benefits in the standard benefits package.

The bill, however, does not specify the standard benefits package. The bill provides guidelines for covered services that a Benefits Commission would use in recommending a standard benefits package to Congress. The bill also does not specify the amount families and individuals would have to pay in deductibles and copayments. The standard benefits package could include dollar limits on benefits for specific treatments or diseases.

The Benefits Commission and the Congress could review annually the standard benefits package. Thus, dollar limits on benefits could be modified every year.

1. Cynthia B. Sullivan, Marianne Miller, Roger Feldman and Bryan Dowd, "Employer-Sponsored Health Insurance in 1991," *Health Affairs* vol. 11, no. 4, (Winter 1992), pp. 172-185.

CARE UNAVAILABLE FOR MEDICAID BENEFICIARIES

Low-income Americans face numerous barriers to medical care, even when they are covered by Medicaid, the government's health insurance program for low-income persons. Last year, almost one out of five adults receiving Medicaid were turned away by a hospital or a doctor. Another 20 percent had to go to an emergency room for care because they did not have a regular doctor.[1]

In late 1990, Sherri Wilburn of Blount County, Tennessee learned she was pregnant. Although she qualified for Medicaid coverage, neither Sherri nor a social worker at the local health department could find a doctor willing to provide Sherri with prenatal care. Sherri was finally able to schedule her first doctor visit for in her seventh month of pregnancy. Three days before her scheduled appointment to begin prenatal care, Sherri went into labor. Her daughter, Cassandra, suffered brain damage and was hospitalized for months. Cassandra will need special education and ongoing physical therapy. According to one of Cassandra's doctors, Sherri's pregnancy was "complicated by a lack of prenatal care."

CLINTON:

Sherri Wilburn would have her choice of any insurance plan offered in her region with an average premium or lower.

Under the Clinton bill, all Medicaid beneficiaries would have access to the same plans offered by the regional health alliances as everyone else.

For individuals like Sherri Wilburn who are eligible for Aid to Families with Dependent Children (AFDC) or individuals who receive Supplemental Security Income (SSI), the Medicaid program would make payments to the health alliances and allow beneficiaries to choose among all health plans with premiums equal to or below the average.

Those who receive cash assistance would be responsible for very small copayments. They would continue to receive all mandatory Medicaid benefits and any optional benefits that the state chooses to provide that are not included in the comprehensive benefits package.

Sherri's daughter would be eligible for services through a new federal program for low-income children with special needs.

Persons currently receiving Medicaid, but not receiving cash assistance, would obtain their health insurance through their regional health alliance in the same manner as all other persons. Persons with incomes below 150 percent of poverty would be eligible for some assistance with their premium costs.

COOPER:

Sherri Wilburn would be fully subsidized for only the lowest-priced plan offered by her local purchasing cooperative.

Under the Cooper bill, Medicaid would be replaced. The funds would be used to pay the premium for the lowest-priced plan offered by the local purchasing cooperative for individuals and families with incomes under 100 percent of poverty.

All individuals and families with incomes between 100 and 200 percent of poverty would be eligible for some assistance with the cost of the premium for the lowest-priced plan, based on a sliding scale. All individuals and families with incomes under 200 percent of poverty would be responsible for only a portion of the difference in premiums between the lowest-priced plan and higher-priced plans and for reduced deductibles and copayments.

For those with incomes under 100 percent of poverty, the Cooper bill would cover prescription drugs, hearing aids and eye-glasses and other benefits currently covered by Medicaid and not included in the standard benefits package.

CHAFEE:

Sherri Wilburn would continue to be covered through the Medicaid program. The state of Tennessee could choose how to provide her care.

Under the Chafee bill, the Medicaid program would continue. States could choose how to provide care. They could provide vouchers for beneficiaries to purchase care through a private purchasing group; enroll beneficiaries directly in a managed care plan; or develop an alternative way to provide health care. Whether or not Medicaid beneficiaries would have better access to services like prenatal care is uncertain.

The Chafee bill limits the amount that Medicaid spending could increase, without limiting how much private insurance could increase. Private insurance payments to providers would therefore be likely to increase faster than Medicaid payments and providers would prefer patients with private insurance to patients with Medicaid. The access problems of Medicaid beneficiaries would worsen.

1. Kaiser Family Foundation, "News Release: New Survey Shows Significant Gaps in Medicaid Safety Net" (Menlo Park, CA: Kaiser Family Foundation, March 17, 1993).

HIGH PRESCRIPTION DRUG COSTS

An estimated 72 million Americans currently lack health insurance for prescription drugs.[1] Medicare does not cover outpatient prescription drug costs. Elderly persons take more prescriptions, on average, than younger people and have higher drug costs, but less than half (49%) of all elderly Americans have prescription drug coverage.[2] As a result, elderly persons pay almost two-thirds (64%) of their prescription drug costs out of pocket.[3]

Iona O'Neill is an 83-year-old resident of Spring Hill, Florida. Iona's income from Social Security is less than $700 per month. She has no insurance covering prescription drug costs. Iona suffered bladder cancer and now spends $300 per month on medicine. Her income is too high, however, to qualify for any public assistance with prescription drug costs.

CLINTON:

Iona O'Neill would not have to pay more than $1,132 a year for prescription drugs.

As of January 1, 1996 under the Clinton bill, Medicare beneficiaries would be eligible for a new outpatient prescription drug benefit.

After an annual deductible of $250 per person, Medicare beneficiaries would pay only 20 percent of prescription drug costs up to an annual maximum of $1,000 (including the deductible). After reaching that maximum, Medicare would cover all drug costs. The benefit would be part of Medicare Part B. Medicare beneficiaries pay Part B premiums that cover 25 percent of Part B costs. The additional Part B premium for the prescription drug benefit would be approximately $11 per month. After 1996, the deductible and out-of-pocket maximum would increase only for inflation.

Those Medicare beneficiaries who purchase Medigap insurance will also benefit from this new coverage. Three of the ten Medigap policies on the market today have prescription drug coverage. The most generous

COOPER:

Iona O'Neill would still have to spend $3,600 or more a year for prescription drugs.

The Cooper bill would not expand Medicare coverage to include prescription drugs.

For those under age 65, the Cooper bill does not require coverage of all prescription drug costs. A Health Care Standards Commission would define, and the Congress would approve, a uniform set of effective benefits that provide medically appropriate treatment. As part of the uniform set of effective benefits, the Commission also would specify the level of deductibles and copayments.

The uniform set of benefits could be reviewed annually by the Health Care Standards Commission and the Congress. Thus, benefits could be modified or eliminated every year.

The Cooper bill would cover prescription drugs for persons with incomes under 100 percent of poverty.

CHAFEE:

Iona O'Neill would still have to spend $3,600 or more a year for prescription drugs.

The Chafee bill would not expand Medicare coverage to include prescription drugs.

For those under age 65, the guidelines for the standard benefits package include prescription drug coverage. However, the Benefits Commission can eliminate categories within these guidelines and the guidelines do not specify the deductibles and coinsurance individuals and families would have to pay for this benefit.

Under this bill, a Benefits Commission would recommend a standard benefits package, with deductibles and copayments, to the Congress. This benefit package could be reviewed annually by the Benefits Commission and the Congress. Thus, benefits could be modified or eliminated every year.

Under the Chafee bill, the Medicaid program would continue. All states currently provide prescription drug coverage for Medicaid beneficiaries.

prescription coverage available through Medigap has a $250 deductible, 50 percent coinsurance and a $3,000 maximum annual benefit. Medicare beneficiaries who purchase Medigap insurance with some prescription drug coverage will be able to save money by purchasing policies without this coverage *and* see their benefits improve.

All Americans under age 65 also would have coverage for prescription drug costs as of 1998 under the Clinton bill. Under the lower cost-sharing plan, individuals and families would pay only $5.00 per prescription. Under the higher cost-sharing plan, after meeting a $250 deductible per person, individuals and families would pay only 20 percent of prescription drug costs. If an individual's health costs exceeded $1,500 or a family's costs exceeded $3,000 in a year, they would no longer have to make any additional payments for prescription drugs.

1. John Rother, "Statement of the American Association of Retired Persons on the Health Care Crisis in America: A Growing Threat to Economic Security," Testimony before the Joint Economic Committee, U.S. Congress (Washington, D.C.: AARP, September 15, 1993).

2. American Association of Retired Persons Public Policy Institute, "Older Americans and Prescription Drugs: Utilization, Expenditures and Coverage," *Issue Brief Number Nine* (Washington, D.C.: AARP, September 1991).

3. Families USA Foundation, *Prescription Costs: America's Other Drug Crisis* (Washington, D.C.: Families USA Foundation, 1992).

JOB LOCK

American families with a member who has a chronic health condition can easily find themselves in the position of being unable to change jobs because the family is dependent on the health insurance obtained through one family member's job. One in five (19%) workers report that they or a family member are locked in their jobs because new work offers limited or no health insurance.[1]

Melanie and Randy Wood live in Houston, Texas with their three children. After her third child was born, Melanie intended to leave her job to become a full-time mother. At the time, the family had health insurance coverage through Melanie's job. Jordan, now ten, was born with Sturge-Weber syndrome, a congenital neurological disorder. Jordan also has hydrocephalus and needs a shunt to drain excess fluid from his brain. Melanie started calling insurance companies immediately after Jordan's birth and found that Jordan was uninsurable. Since Randy is self-employed, Melanie was forced to return to work in order to keep health insurance for her family.

CLINTON:

Melanie Wood could become a full-time mother and the Wood family would have a choice of health insurance plans for the same premium as everyone else, approximately $2,000 a year.

The Clinton bill would eliminate job lock because it guarantees all Americans affordable, comprehensive health coverage.

As of 1998, all employers would contribute 80 percent of average premium costs for health insurance for workers and their families, or more if they choose. As a result, workers would no longer have to choose

COOPER:

If Melanie Wood became a full-time mother, the family could purchase insurance and would be eligible for assistance with premium costs, but there is no way of knowing what benefits their premiums would cover and what out-of-pocket expenses they would have. This bill would not eliminate job lock for workers who wish to change from a job with health benefits to a job that does not have health benefits.

The Cooper bill would not eliminate job lock. Since employer contributions to health insurance would remain voluntary, most employers who do not contribute to health insurance now would not in the future. Thus, workers would still have to choose between jobs that offer health insurance benefits and those that do not.

Individuals and small businesses could purchase insurance through their

CHAFEE:

If Melanie Wood became a full-time mother, the family could purchase insurance and might be eligible for assistance with premium costs, but there is no way of knowing what benefits their premium would cover and what out-of-pocket expenses they would have. This bill would not eliminate job lock for workers who wish to change from a job with health benefits to a job that does not have health benefits.

The Chafee bill would not eliminate job lock. Since employer contributions to health insurance would remain voluntary, most employers who do not contribute to health insurance now would not in the future. Thus, workers would still have to choose between jobs that offer health insurance benefits and those that do not.

Individuals and small businesses could purchase insurance on their own

between jobs that offer health benefits and those that do not.

This insurance would be affordable for small businesses and individuals because low-wage businesses and individuals would be eligible for discounts on premiums; because no business or self-employed individual would have to spend more than 7.9 percent of their payroll on premiums; and because premiums could increase no faster than inflation by the end of the decade.

Immediately upon enactment, the Clinton bill would prohibit insurers from excluding pre-existing conditions for individuals and their families who were insured within the previous 90-day period. For individuals and their families who were not previously insured, insurers could limit coverage for pre-existing conditions for no more than six months. This bill also would require insurers to accept immediately all newly-hired, full-time employees and their families added to groups currently insured. By 1998, this bill would prohibit exclusions for pre-existing conditions under any circumstances.

If Melanie Wood stayed home with her children, the Wood family would purchase their insurance through their regional health alliance and have the same choices as everyone else in the region. They would be eligible for significant discounts on their premiums based on their income. Based on national average premiums, the Wood family would pay approximately $2,000 a year for comprehensive health insurance. Since Randy Wood is self-employed, that amount would be fully tax deductible.

local purchasing cooperative. The premium cost would be tax deductible, but only up to the cost of the lowest-priced plan. Insurance premiums would vary by age. Any plan that denied coverage to any person, family or group because of one person's health condition would not be tax deductible. For individuals and families who lacked insurance coverage for three months, insurers could limit coverage for six months for any pre-existing condition that appeared in the last three months.

The Cooper bill would not limit the amount insurance premiums could increase each year. It would not provide any discounts to small businesses or self-employed persons, or limit the percentage of payroll they could spend on premiums.

Under this bill, individuals and families with incomes under 100 percent of poverty would be fully subsidized for the cost of the lowest-priced plan and would pay ten percent of the difference between the cost of the lowest-priced and higher-priced plans. Individuals and families with incomes between 100 and 200 percent of poverty would pay a percentage of the premium equal to the percentage their income is above the poverty line for the lowest-priced plan and that same percentage of the difference between the cost of the lowest-priced plan and higher-priced plans.

Since Randy Wood is self-employed, the Woods could purchase insurance through their local purchasing cooperative. Since the Woods' income from Randy's business is 19 percent above the poverty line, the Woods would pay about 19 percent of the premium of the lowest-priced plan. Since Randy Wood is self-employed, this cost would be tax deductible. Since the Cooper bill does not specify a standard benefits package, it is impossible to determine the amount the Woods would have to pay for premiums, deductibles, copayments and uncovered services.

or through a number of local purchasing groups. The premium cost would be tax deductible, but only up to the average cost of the lowest-priced one-half of plans offered in the area. Insurance premiums would vary by age. Plans could not deny coverage to any person, family or group because of one person's health condition. For individuals and families who lacked insurance coverage for three months, insurers could limit coverage for six months for any pre-existing conditions that appeared in the last three months.

The Chafee bill would not limit the amount insurance premiums could increase each year. It would not provide any discounts to small businesses or self-employed persons, or place any limit on the percentage of payroll they could spend on premiums.

Under this bill, individuals and families with incomes under 100 percent of poverty would be fully subsidized for the cost of the lowest-priced one-half of plans offered in the area, and individuals and families with incomes between 100 and 240 percent of poverty could be eligible for some assistance with the cost of premiums. Such assistance would be available only if the federal government realizes sufficient savings in the Medicare and Medicaid programs to fund the premium assistance.

The Woods could purchase health insurance coverage through a number of local purchasing groups or on their own. The premium cost would be tax deductible, but only up to the average cost of the lowest-priced one-half of plans offered in the area.

Since the Woods' income from Randy's business is 19 percent above the poverty line, as of 1999 the Woods would pay about 13 percent of their premium cost, up to the average of the lowest-priced one-half of the plans offered in the area, if premium assistance becomes available. Since Randy Wood is self-employed, this cost would be tax deductible.

Since the Chafee bill includes only guidelines for a standard benefits package, it is impossible to determine the amount the Wood family would have to pay for premiums, deductibles, copayments and uncovered services.

1. Henry J. Kaiser Family Foundation and Louis Harris and Associates. "News Release: One in Five American Families Victim of 'Job Lock.' High Cost and Lack of Insurance Top Reasons" (Menlo Park, CA: Kaiser Family Foundation, October 15, 1993).

LONG TERM CARE AT HOME

At any given time, there are an estimated three and one-half million Americans who have great difficulty taking care of themselves. These persons require assistance with three or more of the five most basic activities of daily living—eating, bathing, toileting, dressing and getting out of a bed or chair. The services that they need are largely non-medical in nature and, as a result, options for financial assistance or insurance coverage are very limited. Approximately half of these Americans currently do not receive any paid home care services.[1]

> *Roz and Harold Barkowitz live in North Miami Beach, Florida. Harold is a 72- year-old retired shoemaker who had to give up his business six years ago to care for Roz, age 67, who has multiple sclerosis. They had to sell their house and move into an apartment because Roz could no longer climb the stairs. They get no outside assistance caring for Roz, only someone who comes to clean once a week. Harold's greatest fear is that something will happen to him and he will no longer be able to care for Roz. He currently spends 24 hours a day taking care of her.*

CLINTON:

Mr. and Mrs. Barkowitz would be eligible for services to assist Mr. Barkowitz with caring for his wife. The new program would ensure such care is affordable.

The Clinton bill establishes a major new program to provide services to individuals with severe disabilities without regard to age. Beginning in 1996, the federal government would provide significant new funds for states to develop plans of care for, and provide services to, persons with severe disabilities.

These persons would be eligible for services that include personal assistance and a wide variety of other services that would help them continue to live in their homes and community. This new program would be fully phased in by the year 2003. Individuals would be responsible for modest copayments based on income.

COOPER:

The Barkowitzes would receive no assistance.

The Cooper bill does not provide families any new assistance with providing long term care at home.

Under this bill, states would become entirely responsible for long term care expenses currently financed jointly by the federal government and states through the Medicaid program. Thus, fewer services could be available than currently.

CHAFEE:

The Barkowitzes would receive no assistance.

The Chafee bill does not provide families any new assistance with providing long term care at home.

1. Data provided by Lewin-VHI, Inc. This estimate includes persons with physical disabilities only. Due to limitations in the data, it does not include persons with cognitive impairments.

EMPLOYERS WITH SKYROCKETING PREMIUMS

The amount American families and businesses are charged for health care has far outpaced increases in family income and business profits. Today, business spending for health care nearly equals the amount corporations make in after-tax profits. By contrast, in 1980, business health care spending amounted to 41 percent of corporations' after-tax profits.[1] If health care inflation had been held to the same rate of inflation as the rest of the economy from 1980 to 1992, health care costs for businesses today would be one-third less than they are. This difference averages about $1,000 per worker.[2]

Roger Flaherty owns a small company, Floor Covering Resources, in Kensington, Maryland. He has two employees, and they are covered by a small group health insurance plan. Both employees have ongoing health problems. In 1987 Roger paid $285 a month to cover these employees. In November 1993, his premiums increased to $885 a month. The business pays the full cost of the insurance. Roger is committed to providing health insurance for his employees, but doesn't know if he can continue to afford it.

CLINTON:

Mr. Flaherty would see his health insurance premiums for his employees go up no faster than inflation by 1999.

The Clinton bill would limit the amount by which all insurance companies could raise premiums. By 1999, American families would no longer have to swallow health insurance premium increases that are larger than general inflation. American families would see larger wage increases and more disposable income and businesses would see less of their profits eaten up by health cost increases and have more money to invest and to create new jobs.

COOPER:

Mr. Flaherty and other employers would see their health insurance premiums continue to climb uncontrollably.

The Cooper bill does not limit the amount health insurance premiums could increase annually. Mr. Flaherty's expenses could continue to increase far faster than inflation. Employers and workers would not be protected from the devastating economic effects of rapidly rising health insurance premiums.

CHAFEE:

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1. Cathy A. Cowan and Patricia A. McDonnell, "Business, Households and Governments – Health Spending 1991," *Health Care Financing Review* vol. 14, no. 3, (Spring 1993), pp. 227-248.

2. Service Employees International Union, *Out of Control, Into Decline: The Devastating 12-Year Impact of Healthcare Costs on Worker Wages, Corporate Profits and Government Budgets* (Washington, D.C.: SEIU, October 1992).

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons, which represent nearly 4,000 neurosurgeons in the United States, are increasingly concerned about the huge gaps in access to health care and the misdirected programmatic priorities in our Medicaid program. This concern is in part influenced by the large number of citizens we treat who are coverage poor. The other factor is the larger societal problems associated with providing care to the uninsured and long term care patients. We have given these issues great thought and propose a public/private structure to address the problems. We know designing such a plan will not be an easy task, nor one to which all parties to the debate will agree. It will require all the courage and acumen available to individual Members of Congress and the Administration. Our professional societies stand ready to be a resource in this effort. To that end, we offer the following three tiered approach to deal with the nation's current near crisis health care problem.

I. Expand the current job-based and public coverage system for acute care access for the uninsured.
II. Reform the public Medicaid system.
III. Adopt a plan for long term care coverage.

I. UNINSURED COVERAGE

It is important to address this problem in an urgent manner. While for 85 percent of Americans the current combined job-based and public approach to health care coverage works, there are 32 million Americans without health care coverage. These numbers are increasing and adversely impacting the health care delivery system at all levels. One need only look at the data on the impact of uncompensated care on the inner city hospital, or suffer with the mother who needs care for a child, but lacks the resources to seek help with dignity, to know we have a profound problem.

Our analysis of the make-up of the uninsured population provides us with valuable insights into possible solutions.

Small employers face increasingly formidable barriers in the private insurance market and large employers are decreasing benefits to limit costs.

Three fourths of America's uninsured are workers or their dependents.

Over two thirds of the working uninsured are employed by firms of 25 or fewer employees. Forty-four percent (6.2 million) work in firms with less than ten employees. Traditionally, firms with less than ten employees account for 11 percent of the nations work force. However, only 33 percent (1 in 3) of these firms provide health insurance. Six million workers are employed by firms of 25 to 100 employees without employer provided coverage.

Eleven percent of the uninsured are self-employed.

It seems therefore, that the best approach to insure coverage of the uninsured population would be to build upon the strengths of the existing system of job based and public coverage.

There needs to be a reassessment of the federal tax treatment of health benefits. The current tax on health benefits is inequitable. We subsidize those in generally better paid positions by providing health benefits with no tax. We do not assist those in the most need of obtaining coverage. The small businesses, the self-employed, the farmer, and those working below 200 percent of the federal poverty level are taxed for health benefits. Under the 1986 Tax Reform Act, small firms and the unincorporated self-employed can only deduct 25 percent temporarily. Incorporated businesses deduct the full costs and the employees receive the benefits as a subsidy.

- Unincorporated business and the self-employed should be allowed to deduct the costs of health insurance premiums.
- There should be a tax cap or limit on tax free insurance. The Congressional Budget Office estimated that if the government taxed annual family health insurance premiums in excess of $3,000 ($1,500 for singles), it would raise an average of $10 billion per year.
- In addition to changing the tax laws, specific insurance subsidies should be given to low income workers to encourage the purchase of coverage.
- Insurance reforms should be enacted to eliminate any disincentives to small employer provided coverage.

(a) Certain enrollment and rating practices in the small group market are impeding the availability of affordable benefits for small employers. These practices must be reformed by the state governments and/or the federal government.

(b) Develop a private market reinsurance system to assure that the small employer groups who present a high actuarial health risk might obtain a basic set of benefits from a private carrier at a rate, for example, no higher than 50 percent of the applicable average market premium.

(c) Establish state pools for uninsured individuals. The pool losses could be funded by general revenues so as to spread the costs.

(d) The Internal Revenue Code (ERISA) must be amended in order for states to require self insured companies to participate in state operated risk pools.

II. MEDICAID REFORM

The second approach we offer is reform of the public Medicaid system of medical coverage for the medically needy. There will always be a population of people that will not be able to get employer provided coverage. Their unemployment or income level will not permit purchase of insurance coverage. There is evidence that family income must be 250 percent of poverty before discretionary income is available to spend on health care.

Public programs fail to cover millions of those at poverty levels because of limited budgets and categorical restrictions for eligibility. For example, in 1987 Medicaid covered only 42 percent of those with incomes below the federal poverty level. Even in families with incomes less than 25 percent of federal poverty level, nearly one fourth were not covered by Medicaid or any other program.

There are two reasons low income people cannot get Medicaid: (1) asset tests, and (2) Medicaid is categorically determined and designed to cover the welfare population, not the medically needy.

In order to be eligible to be screened for the asset eligibility levels an applicant must fit one of the following categories: aged, blind, disabled (SSI), or eligible for aid to families with dependent children. If the categories are not met, the patient, no matter how destitute or ill, with few exceptions, is not eligible for Medicaid coverage.

Three out of four Medicaid recipients are welfare supported. Single people and childless couples are completely omitted, even if penniless. An intact two parent family, headed by a full time worker cannot be covered. In addition to categorical exclusions, tremendous variations in financial standards exist from state to state. Some states set Medicaid asset entry as low as 15 percent of federal poverty level.

Over the years, the federal government and the various states have expanded Medicaid benefits to cover an increasing number of procedures, providers, and services. The number of mandates has increased dramatically to hair transplants, acupuncture, in vitro fertilization, chiropractors, marriage counselors, professional herb prescribers (naturopaths), and podiatrists, among others. There are now some 800 state laws mandating benefits, providers, and services.

- Medicaid needs to be separated from the welfare system. Medicaid needs to have a specified minimum benefit package to include primary care, preventive care, and physician and hospital care. There should be uniform, medically needy, asset determined standards. State mandated benefits add about 20 percent to health care costs and a standard benefit package should override added mandates.
- Long term care coverage should be removed from Medicaid, publicly supported long term care in the United States is financed primarily by the Medicaid program. In the U. S. today Medicare finances less than 2 percent of nursing home care, and private insurance finances about 1 percent. Medicaid finances more than 90 percent of the pubic financing of nursing home care.

In most states, 40 to 50 percent of the Medicaid budget is going for nursing home care which comprises as little as 4 percent of the eligible Medicaid population in

some states. The elderly are competing with the under 65 uninsured adults and children for the available health care dollars. If Medicaid continues to provide long term care coverage 30 years from now on the same terms as today, its expenditures, measured as a net of general inflation, will be triple of what they are now. Add the number of increased medically needy to the system and Medicaid will eventually crumble from the incompatibility and weight of both components.

III. LONG TERM CARE

The third tier of needed medical care concerns a separate long term care program. To that end, we offer the following long term health care plan. We have reviewed many of the Congressional proposals, those of the non-profits, and the plans of the private sector. From our collective experience as neurosurgeons and the insights gained from review of the literature, we believe *any* plan should include certain basic principles. We suggest:

- There should be universal long term care for institutional and home coverage; therefore, no means test associated with coverage.
- Coverage should be available for those citizens under age 65 who meet eligibility requirements.
- The plan should be structured to include private, supplemental insurance reform.
- There should be an administrative requirement for state management, utilization review, training, and certification of home health providers. The federal government would establish minimum standards.
- Existing community-based services should be supported and no disincentives should be created to mitigate against their involvement.

Long term care (LTC) represents the most important, uncovered catastrophic expense facing the elderly population of the United States. In the next two decades, the number of older people will grow rapidly and the number of the very elderly even faster. Because of greater longevity more of the population over 65 will be disabled.

Despite the billions of dollars spent on LTC in the U. S. the system is best known for its inadequacies. Public funded services are limited largely to acute and institutional care. There is a strong bias toward institutionalization and away from home care. In-home supportive care, crucial and most desired by the elderly, is costly and if available not reimbursed by Medicare or Medicaid.

Although LTC is identified with nursing homes, the predominant provider of LTC in the U.S. is the family. Families devote enormous time and resources to the care of disabled relatives. It is estimated that more than 27 million unpaid days of care are provided each week in the U.S. to the disabled elderly. However, in coming decades as the need for LTC rapidly escalates, the number of caregivers able and willing to provide services will decline.

A decrease in birth rates, an increase in divorce rates, and the rapidly expanding proportion of working women will make fewer people available to provide family caregiving services.

LTC is paid for either out-of-pocket by using family income and assets or by welfare. Out-of-pocket spending accounts for about 52 percent and Medicaid accounts for approximately 48 percent of all spending for nursing home care in the U.S.

At an average cost of $22,000 per year, the cost of an extended stay in a nursing home exceeds the financial resources of most elderly. Fifty-four percent of new nursing home admissions in 1986-90 depended on welfare for their care. The average person placed in a nursing home "spends down" to Medicaid eligibility in less than 13 weeks.

Establishing a viable LTC program will require significant fundamental changes in the current structure, financing, and delivery of LTC services. Hopefully, such measures can draw upon both the private and public sectors to share financial resources and responsibility for LTC.

Private Sector

LTC insurance should be developed to assist in financing LTC. As of December 1989, there were 1,500,000 people owning LTC insurance policies, with 118 companies offering LTC insurance either through group or individual plans.

In a recent report, the Health Insurance Association of America profiled the private insurance market as follows.

- The long term care market virtually began in 1985-86 when the number of companies in the marketplace doubled from previous years. Most of the growth in

the past two years can be attributed to the entrance of Blue Cross and Blue Shield plans in the field.

- About 87 percent of all long term care insurers sold individual or group association policies which covered 96 percent of 1.5 million persons who purchased a plan. The average purchase age for individual plans was 72 years while the average age for group association plans was 70 years.
- Only nine insurers had sold coverage to employer-sponsored groups, and only 3 percent of all persons were covered under such arrangements. The number of employers offering this coverage, however, has grown exponentially from 2 in 1987 to 47 in 1989 and another 64 to become effective in 1990. The average age of active employees electing the coverage was 43 years.
- Long term care riders to life insurance policies, which were first introduced in 1988, represented 13 percent of insurers and only 1 percent of persons covered at the end of 1989. The average age of persons purchasing the rider was 51 years. The average face value of life insurance policies purchased with this type of rider was $88,053, although it ranged from $31,560 to $100,000.

It is clear that private insurance companies cannot carry alone the burden of LTC financing. As of 1988 only 1 percent of the elderly owned LTC policies. Few elderly are willing or able to buy policies because of expensive premiums. Premiums for low-option policies range from $318 to $728 per year; high option policies range from $684 to $1,496 per year. Eligibility restrictions are prohibitive as insurance companies tend to screen out those who most need policies.

Studies repeatedly show that public as well as private insurance is needed. Private insurance should be developed to supplement LTC insurance, with co-payments, deductibles, and additional coverage items for those willing to pay. We are encouraged that a large number of states are adopting uniform LTC coverage provisions.

There has been reluctance on the part of the private sector to take the necessary risk in making financial options available for LTC. LTC insurance has been an open-ended risk. It is unpredictable in regards to future inflation and payouts. The elderly may receive fixed indemnity payments in the future which are inadequate to cover LTC expenses due to inflation.

If a public insurance system set limits for co-payments and deductibles for nursing home stays and home health benefits, private insurance would have greater actuarial accuracy in setting premiums for LTC policies. This option should allow participation in an HMO, a continuing care retirement community (CCRC), or a private insurance program. The government would make a fixed payment that reflected the actuarially expected cost had the person stayed in the regular public program.

Public Sector

All LTC services should be incorporated into one public entitlement program that would be a part of Medicare. The federal government should not continue to rely on a welfare program to finance LTC for only low income people. LTC for the elderly should be covered by Medicare and social private insurance, but not by a welfare program.

Everyone should contribute to the program and all who contribute are entitled to benefits. Comprehensive benefits for LTC under Medicare should include substantial cost-sharing and other controls on utilization. Cost sharing is appropriate since a large part of LTC is residential care, i.e., room and board the patient would be expected to pay anyway.

Using a social insurance program for LTC spreads the risk of catastrophic LTC expenses and the cost per person over the largest available population. Universal coverage, available to all who meet eligibility requirements, would prevent private insurers from underwriting only those with little risk. The federal government would not become the insurer for only the most costly.

Coverage

In reviewing various proposals for LTC it appears that certain health and supportive services are universally endorsed as essential. Central to these commonly endorsed coverage provisions is support services for the informal caregivers in the home and community. These include respite care for the home caregiver from the rigors of what is often 24 hours a day care. Periodic respite from the burden would help avoid costly institutionalization. Other accepted home health services are:

- homemaker services
- chore services—home and yard care
- occupational therapy—to develop or maintain reliance
- speech therapy

• physical therapy—to develop and restore function

Hospice care should be included because of potential savings over hospitalization. In addition, the hospice has demonstrated successfully that it offers a humane and caring environment for patients based on a volunteer model. It is essential that coverage include case management and re-assessment in order that the multiple needs of the patient are met and delivered in a cost-effective manner.

Financing Options

Our assumption is that the LTC program would be managed by Medicare; thus the current commitment of the federal government to Medicaid could be transferred to Medicare. Likewise, the current expenditures of Medicare for skilled care could be reallocated to the LTC fund.

- We propose a flat premium for every beneficiary with specified enrollment dates, e.g., age 50 and 65. We recommend a premium waiver for those individuals under 150 percent of the poverty level.
- Entitlement under the program would have a first year of coverage exclusion. The first 360 days of home care or nursing home coverage would be the responsibility of the beneficiary. Private insurance would provide reasonable rates and conditions to cover the first year costs or families would opt to do so themselves.
- Once the federal government entitlements become available (year two and all subsequent years) a co-payment of 30 percent would be required. Our rationale for the co-payment is based on the fact that the beneficiary would require room and board in any event.
- In the case of home care benefits, we would recommend a $500.00 deductible after the first year exclusionary period and every year thereafter.

SUMMARY

Organized neurological surgery has embarked on this effort because of its deep concern regarding the serious access problems experienced by far too many of our citizens, the spotty adherence to quality standards by the industry, and the escalating costs and unavailability of long term care to many of our citizens in need. We believe that the recommendations proposed will help provide that access to those in need both for acute care and long term care and make the Medicaid system available to the medically needy. These reforms would provide a basic level of financial protection, quality care, and access for everyone and we are willing to lend our efforts and resources to work towards that end.

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