Testimony of John Sheils before the Senate Committee on Finance

March 12, 2007

Thank you for this opportunity to address the committee on rising health care costs and its impact on the rapidly growing number of Americans without health insurance. I am a Vice-president with The Lewin Group with 20 years experience in studying and analyzing proposals to reform health care and extend health insurance to the uninsured. We are committed to providing independent, objective and non-partisan analyses of policy proposals. The Lewin Group does not advocate for or against legislative proposals.

The number of uninsured in the US has been increasing by about one million people per year since 1990, despite state and federal efforts to expand coverage under Medicaid and the State Children's Health Insurance Program (SCHIP). During this same period, health care costs have grown at nearly three times the rate of general inflation as measured by the Consumer Price Index (CPI). The rapidly growing cost of health care has strained state and local budgets and driven up costs for employers and workers, resulting in a loss of coverage. Rising costs for employers have handicapped American industry in competing in international markets, reduced wage growth for workers and increased the ranks of the uninsured.

The United States spends more on health care than any other nation in the world. Average spending in the US is currently about $6,500 per person, which is nearly twice per-capita spending in Canada and most European countries. Yet the US lags behind many of these countries in life expectancy and health outcomes. Health care accounts for about 16 percent of national Gross Domestic Product (GDP), and is expected to reach 20 percent of GDP by 2015.

While it is widely recognized here and abroad that the US provides some of the most advanced health care in the world, the access our citizens have to this care is often very uneven. People with typical private employer health insurance have access to a broad range of medical

services, usually with only a minimal co-payment requirement. While the uninsured can receive emergency care from most hospitals, they have much reduced access to primary care and other non-emergent care services. This can include life-extending care for people with serious conditions such a radiation treatments for cancer patients. It also includes primary care that can prevent more serious health conditions.

Access to care for Medicaid participants also can be compromised in states where provider payment levels are substantially lower than the cost of providing these services. For example, payment levels for physician services can be as little as half of what is paid under Medicare, and hospital payments are often substantially less than the hospital's cost of providing these services. The use of managed care in many states has helped assure access for many Medicaid patients as a condition of contracting with the health plan. But there are still many providers who will not see Medicaid patients.

The result of these inequities in access is a de-facto rationing of care for the poor. Some nations explicitly ration care by restricting the acquisition of new technologies and limiting spending for physicians and other providers. In some countries this results in waiting lines for high cost procedures such as coronary surgery and dialysis. For the insured in the US, there is virtually no explicit rationing of care, and nearly immediate access to services. But we do ration care by under-serving the uninsured and enrolling the poor in public programs with inadequate provider payments.

Both the free care provided to the uninsured and the shortfalls in reimbursement for Medicaid services fuel cost growth for employer health plans through the cost-shift. When a provider provides services to an uninsured person who cannot pay, the hospital must find some way to cover these costs. They typically do this by increasing the amount charged to private payers for health services. Similarly, hospitals recover shortfalls in payment under public

programs through additional increases in private payer payments. Much of these "under compensated" costs are shifted to the privately insured, including employer health plans. (Although there is evidence that some of these costs are recovered by scaling back other hospital expenses.)

The cost-shift contributes to a cycle of cost growth that ultimately increases the number of uninsured. When costs are shifted to private employers, employer premiums increase. This can cause employers to discontinue coverage or pass the costs back to the worker by reducing covered benefits and increasing the employee contribution requirement (The available data indicates that the employee share typically increases in proportion to the overall cost increase to the plan). In many cases, the increase in the employee premium has caused some people to decline to enroll in the health plan offered at work because they cannot afford the employee contribution. There are about six million uninsured workers and their dependents that have declined the coverage offered to them through work, presumably because they can not afford the premium contribution. While there has been a small decline in the percentage of workers offered coverage through work, most of the loss of employer coverage in recent years is attributed to an increase in the percentage of workers who decline to participate in their employer's plan.

There is also a cost-shift across employers and industries attributed to coverage for working dependent spouses of covered workers. Nearly all insuring employers offer a family coverage option where the worker can cover their spouse and children as dependents. Employers cover about 20 million spouses who are actually working in other firms. Thus, the costs of covering workers in non-insuring firms are often shifted to insuring firms through coverage of working dependent spouses. This has led to a shift of worker health costs from low-coverage industries such as retail trade and services, to high coverage industries such as

manufacturing. Thus the lack of universal coverage in the US further increases health care costs for the very industries that compete most in international markets.

Rising health care costs for insuring firms also slow wage growth for workers. When employers experience an increase in health benefits costs they must either pay for the increase or reduce worker benefits, as many employers have done. However, increases in employer health spending limits the amounts that employers can provide in wage increases, resulting in slowed wage growth throughout the country.

Society incurs many other costs due to having such a large portion of the population without health insurance. It is widely reported by emergency care providers that they often provide treatment to uninsured patients for serious conditions that could have been avoided with proper preventive care. In particular, uninsured people with chronic conditions such as diabetes are often admitted for complications that could have been avoided with primary care and prescription drugs had they been insured. In fact, the Institute of Medicine (IOM) reports that about 18,000 uninsured people are admitted every year as a result of being uninsured. There are other economic costs due to a lack of coverage including more work loss days. Additional days of lost schooling for children could also diminish productivity for the next generation of workers.

The rising cost of health care is the chief cause of the increase in the proportion of Americans who are without coverage. As costs increase, fewer and fewer employers and individuals can afford to purchase health insurance, which places an added burden on state and local governments, safety-net providers and employers via the cost shift. The dilemma is finding a way to slow the growth in health care costs without forfeiting the advances in medical technology that are improving the quality of life for many Americans.

It is essential to recognize that the health care system provides new and improved services each year. For example, while there was little that could be done to treat AIDS sufferers in 1980, there are now treatments that can extend life indefinitely. Similarly, the advent of new procedures such as hip and knee replacements can dramatically improve the quality of life for recipients. We can not expect to benefit from continuing advances in medicine without paying for them. This is a world-wide problem. Many other nations are experiencing cost growth similar to that of the US.

One's health insurance card is the "key to the kingdom" of high quality American health care with all of its new medical advances. The fundamental problem with this is that advances in medicine increase the price of insurance to levels where fewer and fewer people can afford the "key" to the health care system. Appropriate health care is evolving into an ever expanding "luxury good" available to only those with the means to pay for it, leaving a growing sub-class of Americans without access to the best American medicine.

Thank You Mr. Chairman