S. HRG. 98-187

HEALTH INSURANCE FOR THE UNEMPLOYED

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

April 21 and 27, 1983

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HEALTH INSURANCE FOR THE UNEMPLOYED

THURSDAY, APRIL 21, 1983

U.S. SENATE,
SENATE COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 9:37 a.m. in room SD-215, Dirksen Senate Office Building, Hon. Robert J. Dole (chairman) presiding.

Present: Senators Dole, Roth, Heinz, Durenberger, Grassley, Bentsen, and Bradley.

Also present: Senators Specter and Riegle.

[The press releases announcing the hearing, and the opening statements of Senators Dole, Roth, Heinz, and Durenberger, follow:]

[Press Release No. 83-128]

PRESS RELEASE

FOR IMMEDIATE RELEASE—APRIL 12, 1983—UNITED STATES SENATE, COMMITTEE ON FINANCE, SD-221 (FORMERLY 2227) DIRKSEN SENATE OFFICE BUILDING

FINANCE COMMITTEE SETS HEARING ON HEALTH INSURANCE FOR THE UNEMPLOYED

The Honorable Robert Dole (R., Kansas), Chairman of the Senate Committee on Finance, announced today that the Committee has scheduled a hearing on two proposals before the Committee to provide health benefits for the unemployed. These proposals are S. 307, a bill introduced by Senators Riegle, Levin, and Metzenbaum, to provide for continuation of health insurance for workers who lose such insurance by reason of unemployment; and S. 951, a bill introduced by Senators Dole, Durenberger, Heinz, Specter, Roth, and Bradley to provide health care coverage for the unemployed.

The hearing will begin at 9:30 a.m. on Thursday, April 21, 1983, in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Dole noted that almost 90 percent of all private sector, nonfarm employees are offered health insurance as a fringe benefit. When these people are laid off, their health insurance coverage stops, generally within one month. As of December 1982, about 5.3 million people had already lost coverage under their employer's health insurance plan. A variety of ways have been proposed to deal with this problem. Some would create block grants, some would utilize existing programs, some are short term, and some long term. This hearing is designed to provide an opportunity to the public, Members of Congress, and the Administration to comment on the various legislative options being considered by the Committee.

[Press Release No. 83-132 (Revised)]

PRESS RELEASE

FOR IMMEDIATE RELEASE—APRIL 22, 1983—UNITED STATES SENATE, COMMITTEE ON FINANCE, SD-221 DIRKSEN SENATE OFFICE BUILDING (FORMERLY 2227 DIRKSEN)

FINANCE COMMITTEE RESCHEDULES ADDITIONAL HEARING DATE ON HEALTH BENEFITS FOR THE UNEMPLOYED

The Honorable Robert Dole (R., Kansas), Chairman of the Senate Committee on Fianance, announced today that the Committee has rescheduled the second part of its hearing on health benefits for the unemployed, originally scheduled for Tuesday, April 26, 1983.

The hearing has been rescheduled for 1:30 p.m. on Wednesady, April 27, 1983, in Room SD-215 of the Dirksen Senate Office Building.

The Administration is expected to present its views on proposals to provide health benefits for the unemployed. P.R. #83-132 (Revised)

OPENING STATEMENT OF SENATOR DOLE

As a result of the unusually high rates of unemployment in the United States today, a growing number of workers and their families have lost their employment-based group health insurance, and their employers' contributions toward the purchase of such coverage.

An April 1983 report prepared by this committee points out that loss of group health insurance for those who have lost their jobs in not a new problem, but the growth of the numbers of workers who have lost their jobs and the duration of such unemployment is unprecedented in modern times and makes the matter of particular national concern. It is certainly not a new issue to the Finance Committee. In March of 1975 the committee staff also prepared a report for committee use in examining the issue of health insurance and the unemployed.

We know that the majority of the labor force in the United States is covered under group health insurance through their place of employment. This coverage is generally inexpensive because group coverage is substantially less in cost than individually-purchased insurance, and because the employer frequently pays most or all of the premiums.

In recent months, many Americans lost coverage under their former employer's group health plan within one or two months of being laid off. At a time when they can least afford it, laid off workers must turn to nongroup coverage and that coverage is more expensive and often less comprehensive than that which was provided through their employment. The simple fact is that they cannot afford such coverage and they certainly can't afford the cost of care when it is needed—particularly when that care requires a hospital admission.

OPTIONS FOR ASSISTANCE

This Senator has raised the question before—How do we provide some element of protection for these Americans? Certainly we could require that employer plans extend coverage to the unemployed for longer than the one- or two-month coverage most now offer. That, however, imposes a direct financial burden on employers and it is those employers that we look to for new hires and rehires as we get the economy moving again. Clearly any added financial burden on the employers of the Nation at this time is not an appropriate solution. This option also poses no solution for those who are currently unemployed.

We could establish open enrollment for medicare, but that program is hardly healthy, given its current increasing beneficiary population and rising costs. Medicare is designed to be a benefit related to retirement, not temporary job loss.

There is always the option of medicaid, but to open up the entitlement to that program means an enormous committment of State and Federal funds that we are unable to finance at this time. Yet there are aspects of the medicaid program that could prove quite useful, for example, their claims administration and provider agreements, and the fact that they are used to individuals going on and off the rolls within a relatively short period of time.

And finally, there is the possibility of subsidizing the purchase of private insurance for those who lose their employment-based coverage. But this change would require some time to put into operation and would not be very useful for those currently in need.

THE FOCUS OF OUR EFFORTS

The purpose of the bill the Senator from Kansas introduced is to provide some protection to those individuals who have working spouses with coverage or those who are not able to finance the purchase of private coverage during a period of unemployment and have no other coverage available to them.

This is not a bill which creates a program of national health insurance. It is not a program designed to address the needs of every individual who does not currently have health care coverage.

It is a program designed to assist those who are currently out of work and need some limited assistance to get them through this difficult time. The bigger problems will have to be addressed at some time in the future, but our inability to deal with them now, because of our current fiscal crisis, should not stop us from addressing one problem in some limited fashion.

Our proposal uses both the public and the private sector in addressing the problem.

Clearly our approach is not the only one. We have continued to work with the Administration, along with interested Members of Congress, in the hopes of reaching some agreement on how best to approach the problem. A second part of this hearing is being scheduled for Tuesday, April 26, 1983, at which time the Administration will provide us with their suggestions.

PRIVATE SECTOR PROVISION

In addition to providing some limited public sector assistance for unemployed individuals, we also expect the private sector to continue its efforts to help fill the gaps in coverage.

Under our proposal, employer-sponsored health benefit plans would be subject to a loss of 50 percent of the deduction for employer-provided health care costs if they fail to provide an open enrollment for a specified period of time for persons to change from self-only to family coverage, or to commence coverage for the employee and the employee's family.

CONCLUSION

What we are striving for is a proposal that utilizes the best aspects of the private sector, including voluntary efforts, in addition to a limited Federal role.

I believe action must be taken quickly. There are people out there who are not receiving needed health care, and it is our responsibility to try to assist them.

We look forward to hearing from the witnesses before us today and to hearing from the Administration next Tuesday.

PREPARED STATEMENT OF SENATOR ROTH

Mr. Chairman, as a cosponsor of S. 951, I am very concerned with the health needs of the long-term unemployed, and I support this initiative to provide such benefits to these individuals. I would like, however, to state my concern for one of the provisions of S. 951, the subject of our hearing today.

I am very concerned with the State trigger contained in the bill. This trigger will make States with an IUR of less than 4 percent ineligible to participate in this program which will provide health benefits for the unemployed. I do not feel that this is an equitable distribution of the funds for the program.

Under the medicaid program we do not allow the benefits to be distributed in some States and not in others. Under the Federal supplemental unemployment benefits we do not distribute funds only to some States and not others. The health needs of the unemployed do not differ from State to State, therefore, the availability of benefits should not differ from State to State.

My State, the State of Delaware, has an IUR of less than 4 percent, but this IUR includes some individuals who are long-term unemployed. The State of Delaware is broken down into three counties, New Castle, Kent, and Sussex Counties. The unemployment rates for these three counties for the month of January were 7.9 percent, 10.0 percent, and 9.1 percent, respectively. As in many other States, the urban county of New Castle has a lower unemployment rate than Kent and Sussex Counties, which rely primarily on agriculture and small businesses for employment opportunities. The people in these rural, agricultural areas are ignored in our unemployment statistics, since the urban areas with large populations and lower unemployment rates put a downward pressure on the State's IUR. Just as the other members of the Finance Committee do not want their long-term unemployed constitu-

ents to do without benefits, I do not want to see the long-term unemployed of the State of Delaware to go without health benefits.

Furthermore, the States will receive full funding for training programs under the Jobs Training Partnership Act with the beginning of fiscal year 1984. I am confident that once the States receive funding for their programs under JTPA, and are able to provide training and retraining to a greater number of the long-term unemployed, we will see a decrease in the number of long-term unemployed; therefore, reducing the cost of this program I feel it is necessary to provide the long-term unemployed with necessary benefits for health coverage in all the States, until the recipients are able to receive training and/or productive jobs.

As a cosponsor of this important legislation, I am very concerned with this trigger, and will not hesitate to withdraw my support for this bill if something is not done to eliminate the trigger.

Opening Statement of Senator John Heinz

Good morning. Mr. Chairman, I would like to thank you for the timely manner in which you brought the urgent issue of providing vital medical assistance for the Nation's jobless and their families before this committee. For the past three months, I and many of my colleagues from this committee have labored to produce a pragmatic solution to the pressing medical needs of our unemployed. Senate bill 951 represents a solid, short-term solution to the problem before us today.

In addition, I would like to call this committee's attention to the private sector provisions contained in Senator Riegle's bill as potential long-term solutions to this perplexing problem. I believe we need to put this issue to rest once and for all. Should this Nation again endure a prolonged recession, we will have a workable program in place that will provide unemployed workers with affordable access to medical care.

What concerns me here today is the continued lack of response from this administration on the proposals we in the Senate have labored to produce. This administration has yet to come forth with an initiative which addresses the emergency situation that now exists in States, such as Pennsylvania, with an abnormally high level of unemployment.

As a Senator from Pennsylvania, I know that our present recession has left millions of hard working Americans without jobs. Many of these individuals have worked all their lives, and through no fault of their own, have lost their jobs. Suddenly, these tax abiding citizens cannot pay their mortgage obligations, let alone a hospital bill.

Like the President, my colleagues on this committee and I are concerned about the budget and Federal spending. But the issue before us today is lives, not dollars. Human costs cannot be displayed on the bottom line of our massive Federal budget. In order to be truly fiscally responsible, and humane to our fellow Americans, then we should help finance a short-run emergency medical program for the jobless and their dependents. A few dollars spent on preventive care and timely medical intervention today will save untold millions in future costs.

Opening Statement of Senator Dave Durenberger

Through no fault of their own, millions of Americans have lost their jobs. Unemployment creates many hardships and threatens to unravel many of the dreams Americans have spent years pursuing. A private home, an education, a decent life for our children—all can be threatened by the loss of a job. But perhaps the greatest uncertainty comes from the loss of health insurance protection.

Seventy-five percent of the workers in the American labor force are covered under some type of group health insurance or group health benefits plan through their place of employment. The work setting has proven to be an excellent access point for obtaining health insurance. Employers have developed innovative approaches to providing health insurance protection. Features like multiple choice of health plans, wellness classes, coverage of ambulatory surgery, preadmission testing all have their roots in employer-based health plans.

Employers have also paid most of the costs of group health benefits for their workers. A Department of Labor study shows that 71 percent of the business establishments in the United States, covering two-thirds of all employees, paid 100 percent of the health premiums for their workers. Clearly, employer-based health insurance has its advantages. But it has disadvantages, too, the major one being that when an employee loses his or her job, he or she also loses health insurance coverage. The Congressional Budget Office estimates that about 7.4 million of the more than 12 million persons out of work in December 1982 had been laid off, and that

5.3 million of those laid off workers lost coverage under an employer-based health benefits plan. If dependents are included, nearly 11 million Americans now lack health insurance coverage because the family breadwinners have lost their jobs.

For many, the loss of adequate health insurance is the most unnerving consequence of unemployment. It is one thing to postpone the purchase of clothes, appliances, or an automobile, but if a child needs surgery, there is no postponing that. And without health insurance, the costs associated with a major illness can be staggering.

We are here today to consider proposals designed to ease the health insurance gap caused by unemployment. I am pleased to be a sponsor along with the Chairman of one of those proposals, a proposal which is a stop-gap measure designed for a particularly acute problem. It is not intended to be national health insurance. It is a blend of public and private initiatives that addresses the immediate and temporary needs of those Americans who have lost their group health coverage as a result of separation from employment.

On the private side, the proposal establishes a new condition under which an employee may change coverage in his health plan or initiate coverage. If an employee's spouse loses a job—and with it health insurance coverage—then the employee will be allowed to change to or initiate family coverage, provided the employer offers it. Most employees now have the option of switching to family coverage when they get married or have a child. Now they will have the same option if the spouse loses his or her job.

On the public side, the Federal Government will make $750 million available to the State in each of two years through Title XX of the Social Security Act. Dollars will be allocated to the States based on a formula which reflects long-term unemnployment. Thus, the States which carry the heaviest burden of long term unemployment will get more money.

I recognize the proposal is limited in what it provides. The current climate of fiscal austerity simply doesn't provide the basis for a larger program. The money isn't there.

The program's two-year term and its $750 million per year cost reflects our recognition of two problems—the need for a program and the limited funds to do more. Clearly we have taken a conservative approach with this proposal. As time goes on and conditions change, we may be in a position to modify the program. This proposal is a temporary answer to a specific problem. We don't know what the situation will be like six months or two years from now—but presumably, given the experience with this limited program, we will be able to react when the time comes.

The proposal limits enrollment eligibility to unemployed workers who are entitled to receive cash benefits under the unemployment insurance program. As part of the conservative approach in designing this program, some limitations on cost, duration, eligibility, and benefits had to be introduced. The restriction of eligibility to unemployed workers receiving cash benefits links the program to that segment of the unemployed workforce that is most at risk. These individuals have just lost their jobs and can be expected to rejoin the workforce in the short term. Workers who have been out of work for longer periods become less likely to seek employment and are more likely to become eligible for other programs such as medicaid.

As some have suggested, medicaid is not the resolution to this problem. Eligibility for medicaid is linked to actual or potential receipt of cash assistance under the aid to families with dependent children (AFDC) program and the Federal supplemental security income (SSI) program for the aged, blind, and disabled. Few if any unemployed workers would qualify for SSI as aged, blind, or disabled. Entry into the medicaid program principally depends on eligibility for the AFDC program. However, only 23 jurisdictions offer AFDC cash assistance to children in two-parent families who are needly because of the unemployment of the principal wage earner. AFDC program eligibility for unemployed workers is limited because their UI benefits, other income, and their assets generally disqualify them from coverage. For example, equity is limited to no more than $1,000 in resource other than the family's home and one automobile.

The proposal limits coverage to hospital services, physician services, and prenative/post-partum care. The benefits that will be available through the plan are designed to provide a form of catastrophic protection. For example, we do not cover dental care, nursing home care, or home health care. Given the limited number of dollars available, we believed it was necessary to target our resources.

Adequate prenatal and post-partum care often helps to avoid costly institutional services to the mother and to the newborn. Because of this, it was believed that insuring that these services are also available was as important as coverage for other services and institutional care.

The proposal requires the States to provide at least 5-percent, but no more than 20-percent, match funds in order to receive Federal funds. Today most of the States that are experiencing very high unemployment are the same States that are suffering budget deficits. Clearly, these States can not afford to bear a great deal of the cost of this program. For example, in Michigan, the State is being forced to lay off State troopers because it cannot make ends meet. This doesn't mean, however, that the States should be free of any financial participation.

Some financial participation on the part of the States is consistent with the philosophy that both the Federal and State are participants in meeting this need. States should have to make a commitment, no matter how small.

The State participation required is certainly not onerous. Not only is the rate of matching small but the States are also allowed to use the enrollees' premiums if may collect to meet its financial matching obligations. This matching requirement encourages the States to collect these premiums, which we believe to be an important aspect of the program.

States will be required to use existing programs in spending the money. Thus, no new administrative structures are created. Eligibility will be determined through the unemployment compensation system, and health benefits will be managed and paid for through the State's fiscal agency established under medicaid.

States will have the options of requiring a premium payment and imposing modest cost sharing. In no case may a premium payment exceed 8 percent of an individual's unemployment compensation check. Coinsurance and deductible amounts are limited to 10 percent of a State's average unemployment check.

As you can see, the program is based on the employer model of health insurance. Eligible individuals have the option of signing up for coverage just as they do in the private sector. If they do sign up, they may have to make a premium payment, which would be deducted from their unemployment check. The requirement of a premium helps to maintain in peoples' minds a relationship to private insurance. Our program is not designed to be a welfare program. It is designed to temporarily assist people during a period of unemployment. Because the individuals targeted by this program have a history of work, and are currently receiving benefits that generally exceed the State AFDC payments, they can reasonably be expected, on average, to be able to bear a small portion of the costs of their benefits.

Fortunately, the key economic indicators tell us that we are pulling out of the recession. Our economy is on the rebound. It will take time, though, before the recovery creates enough new jobs to bring down our staggering rate of unemployment.

Those who have been unemployed need our assistance now. Congress just completed action on the Jobs bill. Now we have the opportunity to lend another helping hand to the unemployed by giving them the peace of mind that comes with health coverage.

I look forward to hearing from our witnesses today, to learn what is presently being done to assist the unemployed with their health care needs, and to learn best we might bolster that effort.

The CHAIRMAN. Let me first of all indicate that we think we have a good number of witnesses, and a good hearing with excellent witnesses who can give us an insight on this entire problem.

We will also have another hearing at 10 next Tuesday, on the 26th of April, at which time we will hear from the Administration witness; whether it's Mr. Stockman or someone else I am not certain of at this time.

But I do have a letter from Mr. Stockman thanking us for the invitation to appear, indicating that:

> The administration has not yet made a decision. We are hopeful that our study will be completed this week, and that we will be able to share the administration's views on the subject with you early next week.

I think there is a Cabinet-level meeting today on this issue, so perhaps by next Tuesday they will be in a position to make recommendations or suggestions, or at least some indication of where the administration is on this issue.

I would ask that that letter be made a part of the record.

[The letter follows:]

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., April 19, 1983.

Hon. ROBERT J. DOLE,
Chairman, Committee on Finance, U.S. Senate.

DEAR BOB: Thank you for your invitation to testify before your Committee on the question of health insurance for the unemployed.

As you know, the Administration has been studying this problem since we discussed the matter some weeks ago. We are hopeful that our study will be completed this week, and that we will be able to share the Administration's views on the subject with you early next week. We will not, however, be able to complete our work in time to appear before the Committee on Thursday, April 21.

For this reason, I hope it is possible to schedule a second day of hearings next week to hear Administration testimony should you go forward with the Thursday hearing as planned.

In any event, I apologize for the delay in preparation of the Administration's testimony, and regret any inconvenience this delay may have caused.

Sincerely,

DAVID A. STOCKMAN.

The CHAIRMAN. I also have an opening statement which I will just summarize, because we do have a number of witnesses, and I know that Senator Specter and I think Senator Riegle have other obligations.

I would just say that this is a serious problem. It's a real problem for some thousands and thousands of Americans. We have been searching for ways to address it without creating some broad new entitlement program that would be around forever, and we have been searching for the most cost-effective ways and a way that would have the most impact.

We are now in a position to at least hear a number of experts in the area who can raise questions. Senator Roth wants to raise a question that I think has some validity. We have a lot of options.

We know there is a problem, and that's how do we provide health care for the unemployed, and we want to explore some of those options.

I want to congratulate all of the Senators who are here this morning who have played an active role, as well as Senators Specter, Riegle, Levin, Metzenbaum, and others.

So I will just ask that my statement be made a part of the record, and we'll move on to the early-bird here, Senator Roth.

Senator ROTH. Mr. Chairman, I will be very brief, too, and would ask that my complete statement be included as if read.

First I would like to congratulate you for your leadership in this area. I think it's important that we be concerned with the health needs of the long-term unemployed and for that reason I am pleased to support your initiative to provide such benefits to these individuals.

I am, however, very concerned with the State trigger contained in the bill. This trigger will make States with an IUR of less than 4 percent ineligible to participate in this program to provide health benefits for the unemployed. I do not believe that this is an equitable distribution of the funds for the program. Under the medicaid program we do not allow the benefits to be distributed in some States and not in others. The health needs of the unemployed do not differ from State to State; therefore, the availability of benefits should not differ from State to State.

Mr. Chairman, at the appropriate time I will move to strike the trigger so that we treat everyone the same irrespective of where they are, and I look forward to working with you on this important piece of legislation.

The CHAIRMAN. I thank the Senator from Delaware, Senator Roth, and you do make a good point. That's a scenario that we know must somehow be resolved because, as you point out, whatever the rate is, if you are without health protection you've got a problem, whether it is in your State or my State or the State of Michigan.

Senator Heinz?

Senator HEINZ. I think Senator Durenberger was in just ahead of me by a couple of minutes, Mr. Chairman.

The CHAIRMAN. Oh, excuse me. All right.

Senator Durenberger?

Senator DURENBERGER. Thank you very much, Mr. Chairman, and I thank you for your leadership on this issue. I think we are all indebted to you for finding time in trying to save the American taxpayers from the repeal of withholding to also care about those people who don't have the earnings to invest in interest and dividend income bearing accounts.

But it is important, in your capacity as chairman of this committee and with your long-term commitment to health policy reform in this country, that you have taken the leadership in this issue.

I express my appreciation to the two Senators from Pennsylvania who have been a consistent spur in our side to see that we address the problem.

To say just one thing about the Dole-Durenberger-et al. proposal, it is not the perfect answer to the problem, that if we want to do something about the problem today, we are not going to get the perfect answer, that one of the reasons that we have put a sunset in the bill is that we will take some time to seek perfection, that we are not trying to cover every unemployed person in this country because that is a problem that can't be resolved the same way for every unemployed person. It is a relatively simple, straightforward piece of legislation that adopts the same concept that is built into private employment insurance, and that is you buy your health insurance coverage with a part of your income. And we have minimized the part of an unemployed person's income that goes into the purchase of health insurance, with the 8-percent and the 10-percent limitation.

In my State of Minnesota, the average unemployment compensation check is about $540 a month, and this limitation that we have built in means a premium of less than $11 a week, certainly not an unbearable burden for people to carry.

Also, I think we are not contemplating the fact that we are going to deliver medicaid-level benefits; we are not going to deliver those United Auto Worker-level benefits in this program. We are going to deliver what people really need—catastrophic coverage, hospital, doctor, prenatal, postpartum coverage—and we are going to do it for 11 million people who today are without that kind of coverage because there isn't an appropriate affordable vehicle in the private insurance system for them to buy into.

So I just say to my colleague Senator Roth, and to Doug Frazer, and to a whole lot of other people we have discussed this issue with: We are not trying to solve the whole problem between medicaid and the three-fourths of the people that are currently employed. We are trying to do something right now for 11 million people.

During the course of this summer we are going to have hearings on medicaid—restructuring the medicaid system, finding out how we take care of that total population. We are not trying to get it all done in one piece of legislation; we are just trying to do something good for 11 million people.

The CHAIRMAN. Senator Heinz?

Senator HEINZ. Mr. Chairman, first, thinking back on our last discussion on the Senate floor on this issue—and I would ask unanimous consent that my entire statement be made a part of the record at this point—I want to thank you and Senator Durenberger for not having just kept your pledge to hold hearings but to have held hearings more expeditiously even than we contemplated. Senator Specter and I are especially grateful, coming from a State as we do where there is an enormous amount of hardship, where we have maybe a little higher rate of unemployment but the duration of our unemployment, as in parts of Minnesota, has been so much more persistent. People having exhausted even the extended supplemental benefits are literally at the end of their resources—their furniture has been repossessed, their car has been repossessed, and in some cases their home is about to be put on the block, with a "For Sale" sign stuck in front, through foreclosure. But even in those cases the people wait in fear of having some illness in the family that requires hospitalization, with no prospect whatsoever of paying that hospital bill.

I thank the chairman for having invited one of my constituents, an unemployed coalminer from Pennsylvania who will be with us later, who will be, literally, a real case history of what can happen. Let me just say I think Senator Durenberger is quite appropriate, quite correct, to note that what we are looking for is a solution to a hardship problem. If we try to solve the problems of all the working poor and their lack of access to health insurance, we probably won't get it done this year and in time to get a bridging program in place to solve the problems of the greatest hardship. If we attempt to find a larger solution we might as well invite the kind of citicism from the President that he doesn't want at this point, given the budgetary realitities, to create a large, new, big entitlement program. So I think Senator Durenberger is right on that point.

By the same token, when the President was in Pittsburgh with Senator Specter and myself, we found him quite sympathetic to the specific problem of the person whose unemployment compensation is exhausted and who is in the situation that I described a moment ago.

I think this President would like to find a solution that meets the criteria that we have just described, notwithstanding some of the advice he may be getting from the Budget Director, Mr. Stockman.

I would only add that time is very short. We have a window of opportunity because of the possible plans of the Senate to go out

the first of July. That is going to require very rapid movement on our part if we are going to have anything of any meaning enacted.

I also want to observe that when Senator Durenberger was saying that we couldn't really afford and we shouldn't have a Cadillac-kind of coverage for these unemployed people, not only did I agree with him but that we in the Finance Committee maybe need to realize, if we haven't already, that it is our tax policy—specifically, the encouragement that we give to employer-paid first-dollar. We ourselves, through the deductibility we give employers for those health benefits they give their employees, do bear some responsibility for the fact that if you are unemployed you can't find an affordable package of health insurance, and therefore that it is most appropriate that here in the Finance Committee we address this issue.

Mr. Chairman, I thank you.

The CHAIRMAN. Senator Bentsen?

Senator BENTSEN. Mr. Chairman, I am glad to be here. I understand that my immediate concern about the 4-percent limitation is one that Senator Roth has addressed, and that you have stated your interest in trying to work something out on it. My own particular State is one that has gone through a dramatic economic change in the last 12 months which has been brought about by what has happened to the peso devaluation and what has happened to the oil service industry. So a place like the Texas border now has all the way from 20- to 50-percent unemployment. The Golden Triangle, has an unemployment rate of some 23 percent. Though we don't have the long history of unemployment that other States have, the problem of unemployment and hospitalization protection doesn't stop at State borders, and we in Texas have areas of serious concern and problems, and I am most appreciative of your interest in trying to work out a way to take care of it.

The CHAIRMAN. Yes. I think Senator Bentsen, and Senator Roth did raise that issue. We are aware of the problem, and we hope we can address it.

We appreciate your emphasizing the concern that you have and that I'm certain other Senators will have when we get into that area. I would ask that any Senators who might have statements, who may arrive later, that they be made a part of the record.

I am very pleased to call as our first witness Senator Specter from Pennsylvania, who has been vigorous in his support of an effort to address this real problem.

I think we are maybe a week behind schedule, Arlen, but we have done the best we could, and we hope by next Tuesday the administration will be forthcoming. We are very pleased now to have your testimony.

STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SPECTER. Thank you very much, Mr. Chairman.

I thank the chairman and I thank the committee for scheduling these hearings so promptly. I had not intended to mention that we were a week behind schedule, but that ties into one of the three points that I propose to make briefly here this morning. I would

ask that my full statement be made part of the record, and I would summarize it in three parts: Need, a requirement for prompt action, and a requirement for a Senate initiative.

When Senator Durenberger said that the Pennsylvania Senators had been a spur in his side, I think it would be accurate to say that we were the spur under the saddle, which would locate the spur at some part of the anatomy other than the side.

Senator Heinz and I have attempted to focus as much attention on this problem as we can to get as prompt action as we can. We have done so because perhaps we have seen more of the need, as our travels through our State and our mail have reflected the growing problem of the unemployed in a number of respects. The issue of the lack of health insurance is a very major one.

The matter came to a crescendo for us when Senator Heinz and I attended a large community meeting in Midland, Pa., on March 5.

Midland, Pa., has become a famous American town because Crucible Steel, which employed 4,500 people, went out of business in this town of about 13,000, and with the virtual sole employer gone the whole town was unemployed.

On that Saturday morning when Senator Heinz and I went there together out of respect for the special problems they had, the auditorium was packed with people. The lead item on the agenda was the problem of absence of health coverage for those who were unemployed.

And these people were having a lot of problems. They were having problems with mortgage foreclosures, problems with natural gas costs, and all the problems that go with being unemployed. But the item that they talked about with the greatest intensity was the absence of health insurance.

Senator Heinz and I decided that that should be our No. 1 priority, and we went to work and put in the legislation on March 15, just 10 days later, S. 811.

And then, as you know, Mr. Chairman, we had perhaps 30 conversations with you during the course of the passage of the social security bill, since we were very much interested in your leadership to head this effort, and you were most cooperative and most receptive. We waited for some response from the administration on the matter. It came to a head on March 23 when you introduced an amendment but then withdrew it because it was unlikely to be successful at that point, because the administration was not prepared.

Then others of us had the option to introduce legislation, to bring the matter to a head, and I think that it would have been highly likely that we could have gotten an affirmative vote. It might not have survived conference and it most probably would not have been enacted into law, which was our practical reason for deferring to you, Mr. Chairman on that issue.

Then within 8 hours after passage of the social security bill, which was accomplished at 2 a.m. or thereabouts on the morning of March 25, you convened the meeting in your office which was attended by many of us who are in this room today, and also Mr. Stockman and Secretary of Health and Human Services Heckler, where I think we made substantial progress on the matter.

Senator Heinz and I had the unique opportunity to secure the ear of the President when we traveled with him to Pittsburgh on

April 7. Of course we would not use the opportunity, closeted with the President in the back seat of the Presidential limousine, to lobby him. That would be inappropriate.

Senator Heinz and Governor Thornburg and Jim Baker and the President and I were riding in that 30-minute car trip from the Pittsburgh airport to downtown, and protocol would prohibit our lobbying, but instead we asked him if he would be interested in knowing what questions he might confront at that session, and he said, "Yes," he was very interested in knowing that. And that gave us an opportunity to tell him about the problems of health insurance for the unemployed.

One of the first questions he was asked when he got to the computer school was about health insurance, and it was not a put-up deal—we tried, but couldn't find someone to ask the question. [Laughter.]

Spontaneously, one of the students asked the question. And the President's answer was very encouraging; he spoke publicly and on the record—and it was later said that that was the only new thing to come out of the trip to Pittsburgh in terms of some new comment from the President—of his interest in the problem and his willingness to do something about it. And he was a great deal more affirmative publicly than he had been privately in the car just an hour ago, which is the evolution of an idea.

I suggest that there is a tremendous need for prompt action. The statistics are in my statement and they are overwhelming, and we all know what they are: 11 million people unemployed, and 90 percent of those who had health insurance plans have lapsed, and the tremendous cost of individual health plans and the need for something to be done about it on a very, very prompt basis.

The final point that I would make is my sense that there has to be initiative from the U.S. Senate on this issue, and initiative from the Finance Committee to move this along.

As you know, Mr. Chairman, you were eloquent in stating on March 23 that if the administration did not act, you proposed to move ahead—I think your words were "with or without the imprimatur of the administration."

We have all been talking to people at the administration, and my sense of the situation is that they have difficulties focusing on this one, and when they do focus on it they don't want to spend very much money.

There are ways to solve this problem without spending very much money, putting it on fairly short order into existing employer plans. This would be another risk which would be covered in those plans. And as group insurance goes and group risks go, it should not be a very expensive item.

But as we see the events of today, more and more leadership is coming from the U.S. Senate on matters which are becoming law. And more and more items are coming from the Finance Committee on that kind of a leadership position. I submit that this is the item which ought now to be in center stage for the Finance Committee, and we should move on it in the U.S. Senate. That is going to be the effective way to get it done.

I am pleased to hear that Mr. Stockman is coming next week. I believe that he genuinely has his own set of problems, and we are

going to have a tug-of-war on this issue as we have had a tug-of-war on many issues. The Budget Committee is illustrative of that fact, and the Armed Services Committee is illustrative of that fact. There are many ways to illustrate, but if this is to be accomplished I think the leadership is going to have to come here and now, and I am just delighted to see this session convened today.

I thank the Chair, and I thank the committee for affording me the opportunity to testify at this time. There will be millions of Americans who will be enormously appreciative for this kind of prompt action.

Thank you.

The CHAIRMAN. Thank you very much, Senator Specter. Your entire statement will in the record. It is an excellent summary.

[The prepared statement of Senator Specter follows:]

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TESTIMONY FOR SENATOR ARLEN SPECTER BEFORE THE FINANCE COMMITTEE
HEARING ON HEALTH INSURANCE FOR THE UNEMPLOYED
THURSDAY, APRIL 21, 1983

Mr. Chairman, Members of the Committee, I thank you for the opportunity to testify before you today on the important issue of health care coverage for the unemployed. I applaud your interest in pursuing solutions to this complex problem. As I stated in our colloquy on March 23, 1983, it is my sense of the situation that the unemployed who are without health benefits have been asked to wait too long already.

According to the Congressional Budget Office, almost 90 percent of the unemployed in the United States, or close to 11 million persons, have already lost employer-based health insurance coverage -- most within 30 days of job termination. In Pennsylvania, almost 400,000 people who have dependents receive unemployment compensation but have lost their health insurance.

Senator Heinz and I have collaborated for the past several months on a health program, and its importance was emphasized to us when we were in Midland, Pennsylvania about a month ago. A survey published in a Pittsburgh Press article, March 10, 1983, reveals that three of four of Mon Valley's unemployed are without any medical coverage. At least one of every five has immediate need of medical care.

In Washington County, Pennsylvania, Canonsburg General Hospital is providing free medical service to unemployed workers and their families who no longer have insurance. The hospital workers have volunteered their services to help unemployed workers who live in the area and who have been delaying necessary medical treatment and surgery for lack of income and insurance coverage.

But how long can hospitals, clinics, health centers and health service employees continue to absorb the increased costs? In Mobile, Alabama for the month of March all of the hospitals but one had to close their emergency rooms on weekends to curb the flood of requests for free care in order to avoid bankruptcy. Fortunately, for now, the county and city have been able to provide some assistance.

As of April 15, 1983, McKeesport Hospital (PA), a Hill-Burton recipient, had to lay off 51 employees "across the board". Twelve of these are nurses and three are Licenses Praticing Nurses. Some of the physicians indirectly have been cut back due to the losses the hospital is experiencing. This is a decrease of almost 3% in the hospital staff. Can we afford to run the risk of closed hospital doors nationwide?

In talking with various health providers, we are learning that many of the unemployed who are ill do not know where to go for treatment. We are discovering that one of the major fears of the unemployed is fear itself. The uncertainty of "what will

I do if someone in my family becomes ill" plagues them constantly. Early action on health care legislation will help the unemployed find peace of mind with regard to health coverage. The unemployed workers need assurance as well as insurance that their needs will be met.

The Bureau of Labor Statistics has issued recent reports on the total annual consumption costs for both three and four-person families. It has calculated the national average weekly benefit under the states unemployment insurance programs. For example, a three person family accustomed to an intermediate level budget of $14,960 would receive $8,224 in unemployment compensation, which is approximately 55% of previously received income. Moreover, this compensation is only 5% more than the poverty threshold for a comparable family unit. However, if this family had no income, it would be eligible for $10,164, nearly 25% more than the amount available through unemployment compensation.

I cite these statistics to make a point: many people who have worked hard all of their lives are now finding themselves in the unwanted situation of being a poverty level statistic and living below the poverty level.

I am pleased to see that this bill includes the basic concept of S.811 which was introduced by Senator Heinz and me on March 15, 1983.

Our original bill was intended to be a short-term, but immediate solution to the problem of lack of health care coverage for the unemployed. It was to give the states the revenues and

the flexibility to establish a program which would service its constituency, including the options "to provide for cost-effective bidding among carriers or providers, or capitation reimbursement systems, while taking into account the existence of related programs or financing structures in given areas."

The states know best which areas are in most need and what facilities are available. While the ultimate solution would be to provide the unemployed workers with a health insurance policy similar to what they have been accustomed, the costs most likely will be prohibitive. It is my understanding that Blue Cross of Western Pennsylvania has a proposal before the Pennsylvania Department of Insurance which would establish a low-cost health insurance program for unemployed people who have lost their benefits. The plan was just approved yesterday April 20. plan provides for up to 15 days of inpatient hospital care, at a cost of $28.15 per month for individuals and $62.20 for families or a 31-day plan at a cost of $32.90 for individuals and $72.90 for families. In Pennsylvania, the average monthly unemployment benefit is $568. Carrying a policy for $62.20 would be 11% of that family's monthly income.

Even if the government were to decide that health insurance coverage was the best way to go, and would subsidize the policies, say by $52.20 for a 15-day policy for families and the unemployed had to pay $10 of the premium, in Pennsylvania alone with 400,000 needing coverage, it would cost the federal government $20,880,000 each month and $250,560,000 per year. With a federal government subsidy of only $10 per month per premium for 400,000 people, it would cost the government $4 million per month, and $48 million per year for PA. Still, those figures only include those workers who are receiving unemployment compensation.

And this is funding individuals and families who may never need medical attention within that year. My goal is to help those individuals who do have health problems when they occur and give all of those who have lost their benefits the peace of mind and assurance that they will be covered when the need arises.

And this need not be as expensive a situation as one might first assume. In a report (Committee Print 98-A) prepared for the use of the House Subcommittee on Health and Environment, a 1974-75 study regarding high unemployment problems in those years states it is "estimated that no more than 10 to 14 percent of workers losing group health insurance substituted individual nongroup health insurance." The probability of a two-earner household losing health insurance due to unemployment of the head of the household was reduced by 27%. Indeed, our plan is meant to be a payer of last resort and an unemployed worker whose spouse has coverage would not be eligible.

In addition, in Pennsylvania, for 1982, the average length on unemployment compensation was for 18 weeks or 4 1/2 months. While the period of unemployment does not necessarily coincide with the period of loss of benefits, it generally works out to the same amount of time as lack of insurance. This statistic may be important from the standpoint that the majority of unemployed are not going without coverage for an excessive amount of time to warrant the administrative details of signing up for an insurance policy. However, in the event that a catastrophe should occur or a chronic illness need attention in those few months, the unemployed need assurance that they will be treated. The additional

burden of mental anguish over reimbursement should be alleviated from the unemployed worker.

In no way do I mean to downplay the graveness of the situation -- that should be apparent by my persistence in obtaining a meeting with the Administration on March 25, and these very hearings, not to mention lobbying the President personally on April 6. However, the urgency of the need leads me to strive for a workable and financially acceptable solution which can be implemented as soon as it is passed by Congress and signed by the President. This short-term solution should not be bogged down with red-tape and administrative nightmares which will hold up the process any longer.

I would like to take this opportunity to encourage the states to look at the existing health services such as Health Care Centers, Health Maintenance Organizations, public hospitals and even the example in Detroit, Michigan, "Project Health Care." I understand that this project is operating successfully in a city which has had an overwhelming share of the unemployed problem. Briefly, it is a program which provides a health service referral network using the existing social service agencies. It has approximately 360 physicians who volunteer their services and see the patients in their office as they would any other patient. The system is able to handle 1000 patients per month and yet to date, it has not had to serve that many in any one month.

Reimbursement is worked out between patient and the doctor. It is my understanding that there have been no physician complaints about unnecessary visits or abuse of the system, nor any complaints

from the patients that they received second-class treatment. If hospital tests or treatment is required, the physicians use their same hospital privileges and the hospital usually has a social service counselor who assists the patient in determining suitable financial assistance. What is even more encouraging about the program is that the original funding for the program was a $63,000 grant from the Hudson-Webber Foundation. That grant enabled the Greater Detroit Area Health Council to hire a coordinator to recruit the physicians and set up the system.

It is unfortunate that more accurate data is not available. However, I would like to share some recent statistics provided to me by the McKeesport (Pennsylvania) Hospital which has recently established a special program for the unemployed.

The first week of the "Health Concern" program, 100 people inquired about services. Thirty-five were in need of immediate care. Only 25 of those 35 were eligible for the program. Eligibility is based on total monthly household expenses in excess of total monthly income. Those ten who were ineligible were still on unemployment compensation. One of the patients who arrived was a single unemployed mother with three children who had a pace-maker which had not been checked for 18 months because she was afraid to go in due to lack of coverage.

Some of the unemployed patients now qualify for Hill-Burton (McKeesport is a Hill-Burton Hospital) which proves my point about the long-termed unemployed now becoming poverty statistics.

Here is an additional figure which may be of interest. In this same hospital's outpatient clinic, a survey was done for February and March of 1983. Within that clinic, 80% of the patients seen were unemployed. In McKeesport, as of February, 1983 the unemployment rate was twenty-one percent.

The McKeesport Hospital reports that it lost one million dollars in operating costs in 1982. Obviously, if additional funds were available, the hospital would not have had to release those 51 employees which I mentioned earlier. Through the block grant system, the states would be able to assist those health services providers which are located in high unemployment areas and which have seen dramatic increase in patients.

The Canonsburg General Hospital in Washington County, PA, is a private hospital where all of the employees have volunteered their services to help unemployed workers who live in the area and who are delaying necessary treatment and surgery for lack of income and coverage. The data provided to me by this hospital is that in the past two months, 120 unemployed workers or a member of their family have been given free health care. In Washington County, the unemployment rate is 18.9%. Twenty out of the 38 active physicians in this hospital are participating in the program. One of the major concerns of the individuals taking advantage of this hospital's generosity, is not for the unemployed worker or spouse, but for the health of the children.

Once the states set up their mechanisms for providing health care, it is imperative that an outreach program be implemented

to notify those eligible. A letter to all of those who were or are on the rolls of unemployment compensation during the designated eligibility period informing them of what the state has designed and where they can go for help is one simple method. Perhaps this letter could include a brochure on preventative health tips. This would provide the assurance, which I must emphasize once more, that government officials are concerned and are prepared to assist them in the most expeditious, yet economical, and equitable way possible.

It will take a tremendous commitment from the United States Congress and Government to help those people who have lost their health benefits through no fault of their own. Millions of men, women, children and even unborn children are being exposed to the hazards of poor health care due to unemployment.

The need for health care coverage for the unemployed can no longer be overlooked. We cannot run the risk of having the health of breadwinners and future breadwinners deteriorate to the extent that they may be unable to return to employment once the economy recovers.

The CHAIRMAN. I share your concern that it is probably now time to do something. I understand—again, it is only rumor—that there are sympathetic ears in the White House. I'm not certain whose ears they are, but maybe we will find out next Tuesday.

But I appreciate your persistence, and we are going to do everything we can and hopefully find some way to pay for the cost. We understand the overall budget problem.

Senator Durenberger, Senator Heinz? Do you have questions?

Senator DURENBERGER. Just a comment to congratulate you for using your 30 minutes well in the Presidential limousine. I remember the only time I had that occasion we were driving through a Minnesota blizzard and the large 6-foot snowbanks. There was one lone picket perched on a snowbank with a sign that said, "Make love, not cones." The distinguished co-occupant of the vehicle said, "What does that mean?" And we then got into a different kind of a discussion. [Laughter.]

I just hope that this news that the President made doesn't suffer the same fate as the news he made in Boston on the corporate income tax.

But I compliment you on your initiative, and I appreciate your testimony.

Senator HEINZ. Mr. Chairman, just one question of my colleague.

We introduced before March 23 S. 811, the Specter-Heinz bill. That bill is not before the Finance Committee; it was referred to the Human Resources Committee.

If the Finance Committee is unable to move ahead, would you urge the Human Resources Committee to do so instead?

Senator SPECTER. That would be my second choice, Senator.

The CHAIRMAN. It would be my second choice, too. [Laughter.]

Senator HEINZ. I think it would be all of our second choices.

Senator SPECTER. But it is not unwise to have noted that possibility.

The CHAIRMAN. Well, we appreciate that recognition.

Senator Bentsen.

Senator BENTSEN. I want to congratulate the Senator, too. I share his concern for the unemployed and their health benefits. Those concerns don't stop at State borders.

I note the utilization of the IUR rate of 4 percent, and yet I have a situation in my home State where we have more unemployed than does Michigan; we have more unemployed than does Ohio or New Jersey or Massachusetts. And yet we wouldn't qualify because of the 4-percent IUR threshold.

A dramatic change unfortunately is taking place in regard to unemployment, but I hope we can work out something—either on your legislation or some of the other bills—to take care of those who have lost their health benefits wherever they are located.

The CHAIRMAN. Thank you very much, Senator Specter.

Senator SPECTER. Thank you very much, Mr. Chairman.

The CHAIRMAN. We are now pleased to have another of our colleagues, Senator Riegle from Michigan, who has been in the forefront of this effort.

Don, we are pleased to have you before the committee. Your entire statement will be made a part of the record. I had hoped that you might be able to summarize it, and thank you very much.

Senator RIEGLE. I appreciate that, and I will summarize. We are meeting in Budget Committee this morning, and hopefully clearing the way for other issues to come here before the Finance Committee, which I know you anticipate with great eagerness.

STATEMENT OF HON. DONALD W. RIEGLE, U.S. SENATOR FROM THE STATE OF MICHIGAN

Senator RIEGLE. I want to thank you for your leadership on this issue today, because the problems of medical care for unemployed persons and their families has really reached a critical level in the country.

I think all of us at one time or another in our respective situations have seen things within our family life, our own personal circumstances, where health care was the difference between life and death. It was the difference between having a chance to have a full life later on down the line.

In our State today, in Michigan, and as well as in other States like Texas, as has just been mentioned, the numbers of unemployed persons who lack health care protection is really reaching crisis proportions, I think, if we view it from the point of the wellbeing of the Nation as a whole.

And while I have drafted a proposal which you have been kind enough to bring forward today for this hearing and for consideration, I want to stress the fact that, while this is the approach which we have been able to devise which we think is a reasonable one and a workable one, I am not wedded so much to a particular approach as I am to the notion that we act on this problem. There may be a better way to do it, and I am open to any reasonable way of addressing this issue

What I am seeing not just in the State of Michigan but increasingly across the country are literally millions of situations where people are not only without work and in many cases without hope, losing their homes and other things, but they are caught in a dilemma where health-care needs just cannot be met—where there just isn't the money for it, there is no health insurance protection—and the situation for those folks is really bordering on desperation.

So I will ask that the full text of my remarks be made a part of the record, and I want to just give you two or three facts; then I will finish.

We are finding that in our State of Michigan the number of persons requiring medical attention having no private insurance help is really reaching a size that is just overpowering the financial resource of the State itself.

Hospitalization rates indicate that people are delaying treatment until they are more seriously ill. They are not coming at a time when we might be able to treat it at a much less-severe level.

The increase in unreimbursed, uncompensated care provided by Michigan hospitals was up 29 percent from 1981 to 1982. It is more than double the 1978 rate, and it's just threatening some community hospitals with insolvency.

We are seeing an unprecedented increase in the rise in infant mortality. We have a situation in areas of the city of Detroit, for

example, where our infant mortality rate now has risen to the level equal to that of underdeveloped countries around the world that we read about in news stories. It seems impossible that that could happen in our day and age and in our major cities, but that's what we are finding.

This infant mortality is directly associated with low birth weight, and that seems to be associated with poor nutrition, unintended pregnancy with a lack of prenatal care, and unemployment and poverty, to mention just some of the essential factors which are bearing on this as we are seeing these kinds of rises in my state.

Briefly, my proposal S. 307 would place conditions upon the tax deductibility of contributions toward employee group benefit plans, requiring a 6-month extension of the work-related health benefit following an employee's involuntary separation.

In addition, the provider of the employee group benefit plan would be required to participate in a State-administered insurance pool, providing an additional year of protection.

In States with sustained high levels of unemployment the Federal Government would contribute 50 percent of the pool. The remaining funding for the operation of the insurance pool would be borne by active employers and employees, providing the unemployed workers the option to production at a low, affordable rate, estimated to be about somewhere between $3 to $6 per week.

In addition, this long-term solution would be augmented by an emergency program designed to provide immediate assistance to those currently unemployed by initially providing coverage similar to medicare, and then providing access to State insurance pools as soon as they are established at the State level.

As I mentioned, under my proposal part of the funds for providing these health care services would be borne by active employers and employees, part by the Federal Government, and to the extent possible by the unemployed worker himself who, I think properly, ought to try to make some contribution to this important health care protection.

In addition, to be sure that the slight new burden on business would not add to unemployment itself, my proposal contains a mechanism for helping active employers and employees within high unemployment states meet their share of this new responsibility.

I want to say again how profoundly I appreciate the initiative of this committee in tackling this problem. I know when unemployment of the scale that we have seen strikes the country and lasts month after month, and the number of people who are hurt by it now, that there is a tendency I think sometimes to not want to address the consequences of that problem. And they are painful to look at.

But I think it's fair to say that the people who are out there in this situation, many of them people who have worked over a lifetime of effort, people in their thirties, forties, fifties, with family responsibilities, desperately need access to medical insurance and medical treatment and medical care.

So I would hope that the committee, in the spirit it is showing today in bringing this issue forward, would follow through with

whatever proposal seems to be one that can earn the support, hopefully on a bipartisan basis.

I am prepared to work with anyone who wants to try to fashion a remedy here on whatever basis—taking whatever parts of my proposal or perhaps yours, Mr. Chairman, or others that might be advanced by the administration, and see if we can't get into play something that can start to meet these profound medical requirements of people throughout the country who are depending on us and who need our response at this time.

[Senator Riegle's prepared statement follows:]

STATEMENT BEFORE
SENATE COMMITTEE ON FINANCE
APRIL 21, 1983

HEALTH INSURANCE FOR UNEMPLOYED WORKERS

SENATOR DONALD W. RIEGLE, JR.

TESTIMONY BEFORE SENATE COMMITTEE ON FINANCE

APRIL 21, 1983

HEALTH INSURANCE FOR UNEMPLOYED

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, INITIALLY I WANT TO THANK YOU FOR PROVIDING ME WITH THE OPPORTUNITY TO PRESENT MY THOUGHTS AND OBSERVATIONS ON THE CRITICAL MATTER BEFORE US TODAY AND TO CONGRATULATE YOU ON YOUR RECOGNITION OF THE SEVERITY OF THE PROBLEM BEFORE US BY INTRODUCING YOUR OWN LEGISLATION AND BY HOLDING THESE HEARINGS THIS MORNING.

WHEN I INTRODUCED MY FIRST PROPOSAL DURING THE 97TH CONGRESS, WHICH WAS DESIGNED TO ADDRESS THE PROBLEM MILLIONS OF AMERICANS WERE EXPERIENCING IN LOSING THEIR HEALTH INSURANCE PROTECTION WHEN THEY LOST THEIR JOB, MY MAJOR OBJECTIVE WAS TO BRING TO THE ATTENTION OF MY COLLEAGUES, AND TO THE PUBLIC AT LARGE, THE SEVERITY OF THE PROBLEM AND THE EXTENT TO WHICH MILLIONS OF AMERICANS WERE EXPERIENCING UNNECESSARY PHYSICAL AND FINANCIAL HARDSHIPS. EVEN THOUGH I OFFERED A SPECIFIC PROPOSAL DURING THE 97TH CONGRESS -- S. 3063 -- WHICH I LATER MODIFIED AND REINTRODUCED AT THE BEGINNING OF THIS CONGRESS -- S. 307 --, I AM EAGER TO ENDORSE ANY APPROACH AND TO VIGOROUSLY FIGHT FOR ITS ENACTMENT IF IT GENUINELY MEETS THE HEALTH NEEDS OF UNEMPLOYED WORKERS WITHOUT PLACING ADDITIONAL FINANCIAL BURDENS ON OTHER LEVELS OF GOVERNMENT THAT LACK THE RESOURCES NECESSARY TO HELP CONTRIBUTE TOWARD SOLVING THIS NATIONAL PROBLEM.

I FELT THEN AS I FEEL TODAY THAT IT IS ESSENTIAL THAT WE QUICKLY RESPOND TO THE IMMEDIATE AND WIDE-SPREAD HUMAN SUFFERING THAT I WAS SEEING AND AM STILL WITNESSING IN MY STATE, WHICH I BELIEVE IS REPRESENTATIVE OF WHAT IS HAPPENING ACROSS THE COUNTRY.

I BECAME AWARE OF A SERIES OF DISTURBING STATISTICS VIVIDLY DRAMATIZING THE UNCONSCIONABLE SUFFERING HUNDREDS OF THOUSANDS OF CITIZENS IN MY STATE WERE EXPERIENCING AS A RESULT OF LACKING ACCESS TO HEALTH CARE SERVICES. RECENT DATA REVEAL THAT ABOUT 10.7 MILLION AMERICANS NATION-WIDE AND OVER HALF A MILLION UNEMPLOYED WORKERS AND THEIR FAMILIES IN MY STATE OF MICHIGAN ALONE, ARE UNABLE TO AFFORD PROFESSIONAL HEALTH CARE AND ARE ALLOWING OTHERWISE EASILY TREATED AND MINOR HEALTH PROBLEMS TO TURN INTO SERIOUS AND CHRONIC CONDITIONS.

LEGITIMATE ROLE OF GOVERNMENT

BEFORE I REPORT TO THE COMMITTEE IN MORE DETAIL HOW DEVASTATING THE LOSS OF HEALTH INSURANCE HAS BEEN TO MILLIONS OF AMERICA'S UNEMPLOYED WORKERS AND THEIR FAMILIES, I WOULD LIKE TO BRIEFLY TOUCH ON THE LARGER ISSUE CONCERNING THE ROLL THAT GOVERNMENT SHOULD PLAY IN MEETING GENUINE HEALTH NEEDS OF AMERICAN CITIZENS. I KNOW YOU ARE AWARE THAT THERE ARE THOSE WHO HAVE ARGUED WITHIN THIS ADMINISTRATION AND ELSEWHERE, THAT GOVERNMENT SHOULD NOT BE INVOLVED -- ALMOST AT ANY LEVEL -- IN MAKING AVAILABLE OR IN THE DIRECT DELIVERY OF HEALTH CARE SERVICES. WHILE THIS IS NOT THE PLACE TO HAVE THIS DISCUSSION WITHIN ITS BROADER CONTEXT, I DO BELIEVE CERTAIN ASPECTS OF THIS DEBATE BEAR DIRECTLY ON THE ISSUE BEFORE US.

FEW OF US WOULD HESITATE IN SEEKING ACTIVE GOVERNMENTAL INVOLVEMENT IN ASSISTING CITIZENS WHO WERE EXPERIENCING EXTREME HARDSHIPS AS A RESULT OF ACTIONS TOTALLY BEYOND THEIR CONTROL. WE RESPOND ALMOST IMMEDIATELY TO ASSIST VICTIMS OF NATURAL DISASTERS - SUCH AS FLOODS AND EARTHQUAKES. WE HAVE SEVERAL PROGRAMS IN PLACE TO LESSEN THE SUFFERING THAT RESULTS FROM A SUDDEN LOSS OF INCOME, DUE EITHER TO DEATH, RETIREMENT, OR DISABILITY.

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WE'VE LONG RECOGNIZED THE NEED TO PROVIDE FINANCIAL ASSISTANCE IN THE FORM OF UNEMPLOYMENT COMPENSATION TO WORKERS WHO ARE INNOCENT VICTIMS OF A POORLY PERFORMING ECONOMY. YET, WHEN WE FOCUS ON THE HARDSHIP RESULTING FROM THE LOSS OF HEALTH INSURANCE, SOME WANT TO ARGUE THAT GOVERNMENT SHOULD NOT BE INVOLVED.

I WONDER HOW MANY AMERICANS, BOTH EMPLOYED AND UNEMPLOYED, BELIEVED THE PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION ON TUESDAY OF THIS WEEK WHEN HE TOLD PRESIDENT REAGAN THAT THE HEALTH NEEDS OF UNEMPLOYED WORKERS COULD AND WOULD BE MET BY THE VOLUNTARY EFFORTS OF PHYSICIANS ACROSS THE COUNTRY?

THE HUMAN SUFFERING THAT SOME HAVE EXPERIENCED AFTER LOSING THEIR HEALTH INSURANCE IS JUST AS REAL AS THOSE NATURAL DISASTERS I JUST MENTIONED; OFTEN THE DIFFERENCE BETWEEN LIFE AND DEATH. I BELIEVE IT IS A LEGITIMATE ROLE, IF NOT A DUTY, OF GOVERNMENT TO PREVENT NEEDLESS PHYSICAL SUFFERING OR FINANCIAL DISASTER AMONG UNEMPLOYED WORKERS AND I'M PLEASED THAT WE ARE MOVING IN THAT DIRECTION.

HEALTH CARE IN MICHIGAN

IN MY STATE OF MICHIGAN, WHERE THE RECENT RECESSION HAS LEFT SOME OF THE DEEPEST SCARS, WE SEE THE EXTREME ASPECTS OF THE PROBLEM, BUT IN NO WAY ARE THEY UNIQUE. RATHER, WHAT WE SEE IS REPRESENTATIVE OF WHAT IS HAPPENING ACROSS THE COUNTRY.

IN MICHIGAN, THE UNEMPLOYMENT RATE HAS EXCEEDED 10% FOR THE LAST CONSECUTIVE 39 MONTHS. OVER HALF A MILLION PERSONS HAVE DROPPED OUT OF THE BLUE CROSS AND BLUE SHIELD PROGRAM IN THE STATE SINCE 1979. YET THE MEDICAID ROLLS HAVE ONLY INCREASED BY 106,000. (RECENT ESTIMATES INDICATE THAT ONLY 10% OF THE NEWLY UNEMPLOYED ARE BEING PICKED UP BY THE MEDICAID ROLLS.)

WHILE THE NUMBER OF PERSONS ELIGIBLE FOR AND PARTICIPATING IN PUBLICLY FINANCED HEALTH CARE AND SOCIAL SERVICE PROGRAMS HAS INCREASED, THE STATE'S DEPARTMENT OF PUBLIC HEALTH HAS LOST OVER $24 MILLION IN FEDERAL AND STATE REVENUES IN THE LAST YEAR AND A HALF.

MANY PERSONS WHO HAVE ALWAYS BEEN HARD WORKING, PRODUCING, TAX PAYING MEMBERS OF SOCIETY NOW FIND THEMSELVES FOR THE FIRST TIME USERS OF PUBLICLY FUNDED HEALTH PROGRAMS IF THEY HAPPEN TO BE THE FORTUNATE FEW WHO ARE RECEIVING CARE THROUGH STATE ADMINISTERED PROGRAMS. SINCE PUBLIC FUNDS ARE WOEFULLY INADEQUATE, BOTH FROM FEDERAL AND STATE SOURCES, MOST UNEMPLOYED WORKERS AT RISK - THAT IS, WITHOUT ANY HEALTH INSURANCE PROTECTION - ARE NEGLECTING NEEDED HEALTH CARE. HOSPITALIZATION RATES IN MY STATE INDICATE THAT PEOPLE ARE DELAYING TREATMENT UNTIL THEY ARE MORE SERIOUSLY ILL. THE INCREASE IN UNREIMBURSED, UNCOMPENSATED CARE PROVIDED BY MICHIGAN HOSPITALS IS UP 29% FROM 1981 TO 1982, MORE THAN DOUBLE THE 1978 RATE, THREATENING SOME COMMUNITY HOSPITALS WITH INSOLVENCY. THIS RAPIDLY INCREASING UNCOMPENSATED CARE, MOSTLY A RESULT OF AN INCREASE IN THE NUMBER OF UNEMPLOYED WORKERS AND THEIR FAMILIES WITHOUT HEALTH INSURANCE, TOGETHER WITH REDUCED MEDICAID PAYMENTS TO HOSPITALS, HAS RESULTED IN SEVERE FINANCIAL DIFFICULTIES FOR THOSE HOSPITALS WHICH SERVE LARGE NUMBERS OF MEDICAID BENEFICIARIES. EVEN THOUGH MOST HOSPITALS IN DETROIT ARE NOW LIMITING THE TREATMENT OF MEDICAID PATIENTS, THERE HAVE BEEN RECENT PREDICTIONS OF HOSPITAL CLOSINGS.

PERHAPS WHAT IS ONE OF THE MORE DISTURBING ASPECTS OF THIS DISMAL REALITY, AND ONE THAT'S BEEN MAKING NATIONAL NEWS, IS THE RECENT UNPRECEDENTED INCREASE IN INFANT MORTALITY. THE RATE OF

INFANT MORTALITY, THAT IS INFANTS THAT DO NOT SURVIVE THEIR FIRST BIRTHDAY, IS OFTEN USED AS A BAROMETER OF THE HEALTH STATUS OF A PARTICULAR COUNTRY OR REGION. OVER THE LAST TWO DECADES, WE HAVE SEEN A STEADY DECLINE IN THE INFANT MORTALITY RATE IN THIS COUNTRY AND MANY HAVE THEREFORE CONCLUDED, I BELIEVE WITH SOME DEGREE OF ACCURACY, THAT HEALTH CONDITIONS IN THE COUNTRY ARE IMPROVING. INFANT MORTALITY IS DIRECTLY ASSOCIATED WITH LOW BIRTH WEIGHT AND THAT IS ASSOCIATED WITH POOR NUTRITION, UNINTENDED PREGNANCY WITH THE LACK OF PRENATAL CARE, AND UNEMPLOYMENT AND POVERTY, TO MENTION ONLY A FEW OF THE ESSENTIAL FACTORS.

THE FACTS ARE THAT IN CERTAIN AREAS OF DETROIT, AN INFANT HAS THE SAME CHANCE OF SURVIVING ITS FIRST YEAR AS A NEW BORN IN SOME OF THE POOREST NATIONS IN THE WORLD. LAST YEAR, MY STATE OF MICHIGAN EXPERIENCED THE LARGEST YEAR-TO-YEAR INCREASE IN INFANT MORTALITY SINCE WORLD WAR II AS THE UNEMPLOYMENT RATE BEGAN TO CLIMB AND THE DURATION OF UNEMPLOYMENT GREW. THERE ARE STUDIES THAT DEMONSTRATE CONCLUSIVELY THAT UNEMPLOYMENT AND INFANT MORTALITY ARE RELATED AND RISE AND FALL WITH GENERAL ECONOMIC CYCLES.

LACK OF HEALTH CARE DUE TO UNEMPLOYMENT IS NOT ONLY DAMAGING TO THE MENTAL AND PHYSICAL WELL-BEING OF UNEMPLOYED WORKERS AND THEIR FAMILIES, BUT AS WE CAN SEE, IT IS ALSO HARMFUL TO YET UNBORN FUTURE GENERATIONS.

POSSIBLE SOLUTIONS

IN CONCLUSION, I WOULD LIKE TO BRIEFLY COMMENT ON THE VARIOUS

LEGISLATIVE INITIATIVES THAT HAVE BEEN DEVELOPED TO DEAL WITH THIS TRAGIC SITUATION. WHEN I FIRST INTRODUCED MY PROPOSAL DURING THE 97TH CONGRESS, VERY FEW MEMBERS OF CONGRESS WERE AWARE OF THE HEALTH CARE PROBLEMS FACING UNEMPLOYED AMERICANS. GIVEN THE EXTREME COSTS INVOLVED IN PROVIDING HEALTH CARE, AND THE LACK OF AWARENESS OF THE PROBLEM AMONG MY COLLEAGUES, I DESIGNED A PROGRAM THAT INVOLVED SHARING THE FINANCING OF THESE NEW HEALTH CARE SERVICES FOR THE UNEMPLOYED AMONG VARIOUS SECTORS OF SOCIETY.

BRIEFLY, MY PROPOSAL -- S. 307 -- WOULD PLACE CONDITIONS UPON THE TAX DEDUCTIBILITY OF CONTRIBUTIONS TOWARD EMPLOYEE GROUP BENEFIT PLANS, REQUIRING A 6 MONTH EXTENSION OF THE WORK RELATED HEALTH BENEFIT FOLLOWING AN EMPLOYEE'S INVOLUNTARY SEPARATION. IN ADDITION, THE PROVIDER OF THE EMPLOYEE GROUP BENEFIT PLAN WOULD BE REQUIRED TO PARTICIPATE IN A STATE ADMINISTERED INSURANCE POOL PROVIDING AN ADDITIONAL YEAR OF PROTECTION. IN STATES WITH SUSTAINED HIGH LEVELS OF UNEMPLOYMENT, THE FEDERAL GOVERNMENT WOULD CONTRIBUTE 50% OF THE COST OF OPERATING THE POOL. THE REMAINING FUNDING FOR THE OPERATION OF THE INSURANCE POOL WOULD BE BORNE BY ACTIVE EMPLOYERS AND EMPLOYEES PROVIDING THE UNEMPLOYED WORKERS THE OPTION TO PURCHASE PROTECTION AT A LOW, AFFORDABLE RATE ESTIMATED TO BE ABOUT $3 TO $6 PER WEEK.

IN ADDITION, THIS LONG-TERM SOLUTION WOULD BE AUGMENTED BY AN EMERGENCY PROGRAM DESIGNED TO PROVIDE IMMEDIATE ASSISTANCE TO THOSE CURRENTLY UNEMPLOYED BY INITIALLY PROVIDING COVERAGE SIMILAR TO MEDICARE AND THEN PROVIDING ACCESS TO STATE INSURANCE POOLS AS SOON AS THEY ARE ESTABLISHED AT THE STATE LEVEL.

AS I MENTIONED, UNDER MY PROPOSAL PART OF THE FUNDS FROM PROVIDING THESE HEALTH CARE SERVICES WOULD BE BORNE BY ACTIVE

EMPLOYERS AND EMPLOYEES, PART BY THE FEDERAL GOVERNMENT, AND TO THE EXTENT POSSIBLE, BY THE UNEMPLOYED WORKER. IN ADDITION, TO ASSURE THAT THE SLIGHT NEW BURDEN ON BUSINESS WOULD NOT ADD TO UNEMPLOYMENT ITSELF, MY PROPOSAL CONTAINS A MECHANISM FOR HELPING ACTIVE EMPLOYERS AND EMPLOYEES WITHIN HIGH UNEMPLOYMENT STATES MEET THEIR SHARE OF THIS NEW RESPONSIBILITY. BY DIVIDING THE FINANCING OF THIS NEW PROGRAM AMONG THE SEVERAL SECTORS OF SOCIETY I HAVE JUST MENTIONED, THE FINANCIAL IMPACT ON BUSINESS, GOVERNMENT, OR THE UNEMPLOYED WORKER IS MINIMAL. FURTHERMORE, UNDER MY PROPOSAL THERE ARE SUFFICIENT FUNDS AVAILABLE TO GENUINELY MEET THE NEED DURING THESE TIMES OF MASSIVE FEDERAL DEFICITS.

IT IS ALSO IMPORTANT TO MENTION THAT EVEN THOUGH NATIONAL UNEMPLOYMENT RATES MAY MODERATE IN THE MONTHS AND YEARS AHEAD, AS WE ALL HOPE, THERE STILL WILL BE AREAS ACROSS THE COUNTRY WHERE UNEMPLOYMENT RATES REMAIN HIGH. AND WE ALL KNOW, NOT WITHSTANDING THE ADMINISTRATION'S ASSERTIONS TO THE CONTRARY, THAT THE BUSINESS CYCLES DO REPEAT THEMSELVES AND UNEMPLOYMENT RATES WILL GO UP AND DOWN OVER THE YEARS. TO CUSHION INNOCENT AMERICAN WORKERS AGAINST THE FINANCIAL HARDSHIPS RESULTING FROM UNEMPLOYMENT, WE HAVE ENACTED A PERMANENT UNEMPLOYMENT COMPENSATION PROGRAM THAT IS AVAILABLE FOR MOST UNEMPLOYED WORKERS WHO HAVE LOST THEIR JOB THROUGH NO FAULT OF THEIR OWN. I FEEL IT IS EQUALLY IMPERATIVE THAT WE ADDRESS THE LONGTERM HEALTH CARE NEEDS OF UNEMPLOYED WORKERS BY ASSURING THAT SOME MECHANISM IS IN PLACE TO DEAL WITH THIS PROBLEM IN THE FUTURE. MY PROPOSAL ENVISIONS SUCH A LONGTERM SOLUTION BY CREATING INCENTIVES FOR STATES TO ESTABLISH HEALTH INSURANCE POOLS TO PROVIDE LOW COST HEALTH INSURANCE TO UNEMPLOYED WORKERS. I AM PLEASED THAT LEGISLATION RECENTLY INTRODUCED BY REPRESENTATIVE

WAXMAN - H.R. 2552 - DEALS WITH THE LONGTERM DIMENSIONS OF THE PROBLEM AND PROVIDES STATES WITH THE FLEXIBILITY TO ESTABLISH HEALTH INSURANCE POOLS. IT IS MY HOPE THAT ANY PROPOSAL ADOPTED BY THIS COMMITTEE INCLUDES A LONGTERM SOLUTION, OR AT THE VERY LEAST, AFTER AN EMERGENCY PROGRAM IS IN PLACE, EFFORTS ARE UNDERTAKEN TO DEVELOP SUCH A PROGRAM AS SOON AS POSSIBLE.

IN CLOSING, MR. CHAIRMAN, I WOULD LIKE TO JUST BRIEFLY COMMENT ON THE PROPOSAL YOU HAVE PUT FORTH TO DEAL WITH THIS CRISIS SITUATION -- S. 951. I COMMEND YOU FOR YOUR INTEREST AND ACTIVITY IN THIS AREA BUT I AM DEEPLY CONCERNED THAT UNDER THE LEGISLATION YOU HAVE DEVELOPED THERE WILL BE INSUFFICIENT FUNDS AVAILABLE TO ADEQUATELY DEAL WITH THE PROBLEM. UNDER YOUR BILL, STATES WILL BE ASKED TO TARGET FUNDS ON A FEW SELECT INDIVIDUALS WHILE MILLIONS OF AMERICANS ALSO REQUIRING ASSISTANCE WILL FIND THEMSELVES IN THE SAME PLACE THEY ARE NOW -- IN NEED OF HEALTH CARE SERVICES. I THINK IT WILL BE EXTREMELY DIFFICULT FOR STATES TO MAKE THE KINDS OF CHOICES REQUIRED IN TARGETING LIMITED FUNDS ESPECIALLY WHEN THE ABSENCE OF MEDICAL CARE CAN OFTEN MEAN THE DIFFERENCE BETWEEN LIFE AND DEATH, WELL-BEING OR PERMANENT DISABILITY.

IN ADDITION, I AM CONCERNED ABOUT PLACING NEW FINANCIAL BURDENS ON STATES, ESPECIALLY THOSE STATES LIKE MY HOME STATE OF MICHIGAN, WHICH ARE IN THE MIDST OF FISCAL CRISES.

I HAVE A LIST OF EIGHTEEN OTHER STATES, THAT ACCORDING TO THE NATIONAL CONFERENCE OF STATE LEGISLATURES ARE ALSO EXPERIENCING SERIOUS FISCAL DIFFICULTIES.

UNDER S. 951, HIGH UNEMPLOYMENT STATES WOULD BE REQUIRED TO SHOULDER ONLY 5% OF THE COSTS OF THE NEW PROGRAM OF HEALTH CARE FOR THE UNEMPLOYED. HOWEVER, IN THE CASE OF MY STATE, MEDICAID

STATES EXPERIENCING SERIOUS FINANCIAL DIFFICULTIES

STATE	DEFICIT AS A PERCENTAGE OF SPENDING FOR FY1933
New Hampshire	2.5%
Vermont	2.5%
Rhode Island	4.0%
Connecticut	1.9%
New York	3.3%
Virginia	3.5%
Louisiana	3.5%
Idaho	16.1%
New Mexico	3.2%
California	4.5%
Washington	2.1%
Pennsylvania	2.2%
Michigan	13.8%
Wisconsin	7.7%
Minnesota	0.2%
Iowa	4.0%
Colorado	6.1%
Utah	0.6%
Arizona	11.9%

Source: National Conference of State Legislatures, February, 1933

IS ALREADY THE LARGEST SINGLE LINE ITEM IN THE STATE BUDGET AND INCREASING RAPIDLY IN THE FACE OF CONTINUED REDUCTIONS IN FEDERAL MATCHING FUNDS. MICHIGAN HAS ALREADY REACHED THE SATURATION POINT AS FAR AS IMPLEMENTING MAJOR COST-CONTAINING INITIATIVES AND OVER THE LAST FEW YEARS MANY MEDICAL SERVICES AVAILABLE TO MEDICAID PATIENTS HAVE BEEN SIGNFICANTLY REDUCED. EVEN A 5 PERCENT STATE MATCH FOR SOME STATES WILL MEAN ADDITIONAL REDUCTIONS IN MEDICAL CARE FOR OTHER NEEDY INDIVIDUALS. THE FINANCING MECHANISM UNDER REPRESENTATIVE WAXMAN'S PROPOSAL -- H.R. 2552 -- WOULD ADDRESS THIS CONCERN, BY SHELTERING HIGH UNEMPLOYMENT STATES EXPERIENCING FISCAL SHORTFALLS FROM BEING ASKED TO INCUR NEW OBLIGATIONS AT A TIME WHEN THEY CAN LEAST AFFORD IT.

AS I MENTIONED IN MY OPENING REMARKS, I AM WILLING TO WORK FOR THE ENACTMENT OF ANY PROPOSAL THAT GETS THE JOB DONE WITHOUT PLACING ADDITIONAL NEW FINANCIAL BURDENS ON STATES UNABLE TO FUND A NEW PROGRAM. I APPRECIATE HAVING THE OPPORTUNITY TO SHARE MY VIEW WITH YOU AND I'M EAGER TO WORK WITH YOU AND OTHER MEMBERS OF THE COMMITTEE IN DEALING WITH THIS NATIONAL EMERGENCY.

The CHAIRMAN. Thank you very much, Senator Riegle.

Again, I want to indicate that you are in the forefront of this effort. It must be bipartisan—I don't see any effort to make it a Republican or a Democratic plan. I think if we are going to do it in a responsible way it must have bipartisan support, and I see that developing. We are going to continue to approach it on that basis.

Hopefully there will be some little room in the budget to help us meet the costs of the program. I know you are working on that.

So we appreciate your statement and your concern.

Senator RIEGLE. I might just say, I've talked with Senator Domenici about that, and I know he has spoken with you. So we discussed directly in the Budget Committee the effort to want to provide some room for a figure that looks like it would be the figure that would meet this need. I know he has said he is open to your suggestions to us as a budget committee, and I think there is support on both sides to try to reach an accommodation to see to it that we try to anticipate this and provide for it.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

Don, I just want to say that I, too, appreciate your efforts. I was stuck in the rain in New York on Saturday and had a chance to watch C-Span, and I benefited from your eloquent comments from the Budget Committee. I think it was about the 13th of April we were watching C-Span-revisited about 3 days.

One of the issues that also got discussed there, which of course is a part of this consideration, discussed perhaps more by our colleague from Ohio, was the whole problem of cost sharing that people are rather sensitive to.

The proposal of the chairman with which I am associated contemplates a certain amount of cost sharing, and of course uses the minimal part of the compensation system to provide for that cost sharing—in part at the premium end, and then in part at the limited part of the service end.

Do you yourself have any problem with that kind of a concept?

Senator RIEGLE. Well, I don't have a problem with the concept; my concern is feasibility, the capacity to pay or the capacity to come up with the money.

As you know, some areas of the country have been so hard hit for so long that State governments and local authorities are really out of money and are in desperate financial shape.

And, in turn, many of the families that we are talking about here have been squeezed down to such a point that, beyond a very nominal kind of participation, I don't think it's realistic to expect them to be able to afford this care. Many of them are going without it now because they can't pay for it.

So, in concept, I think we ought to try to involve everybody in the cost-sharing side of it, from employees and employers that are now working, to the unemployed to the extent that they can help, Federal, and State combined.

But I think balancing that load on the realistic capacity to pay right now is a critical factor. I know in my State of Michigan we have just raised State taxes to an all-time high, and it's creating an enormous disincentive, in a sense, to get the business wheels turn-

ing again in the State. So at some point our taxing capacity at gross levels is just exhausted.

So I think the Federal part is critical here, and perhaps we've got to find some way to scale this for the cases that are more desperate, regionally or State by State, and perhaps we will find a way for the Federal response to be greater.

The CHAIRMAN. During the course of the day today we are going to hear a variety of testimony about how this problem is now being taken care of. Certainly the AMA and the AHA will tell us how much free care, in effect, is always given in this country. It doesn't get much attention anyplace, but there is a whole lot of it going in this country.

Also, I'm sure we will hear some testimony to the fact that even though it may cost $70, $80, $90, or $100 a month, people are finding ways to buy insurance—obviously not everybody by any means, or we wouldn't even be here.

So it is hard to make the argument that health is just as important as food, shelter, clothing, and so forth, unless we also adopt the concept that there is some willingness on the part of all of these unemployed persons to contribute some relatively small part of their current compensation.

I would just hope that you can take the leadership among your colleagues and at least recognize that we can deal with the problem, as we've tried to do in the bill, but we certainly need your leadership to break down the notion that it has to be free, or we'll never get it.

Senator RIEGLE. I will help in that respect, because I think for many reasons it is important that there be a sharing of effort here. And I think both in terms of gaining the political support we need and having the broad support of the public that that is part of it. So I will play my part along those lines.

The CHAIRMAN. Thank you very much.

Senator Bentsen.

Senator BENTSEN. Well, first I want to agree with the chairman when he talks about developing this in a nonpartisan way, and then to say to Senator Durenberger, there is no question but what you have to have some sharing in this to provide the discipline that has to be there; and then to say to my friend Senator Riegle, it is just obvious you are a lot more interested in the results than you are the credits, and that's the way we get these things done. I really appreciate your concern and your interest here—of course, part of that objectivity may be the fact that you've just won reelection. [Laughter.]

Senator BENTSEN. But whatever the reason for that objectivity, I am delighted with the way you are moving on this issue, and your concern, and I know you are going to be productive on it.

Senator RIEGLE. I thank the Senator for his comment.

The CHAIRMAN. Senator Bradley.

Senator BRADLEY. No questions, Mr. Chairman. I think that, having spoken to Senator Riegle before, he speaks very forcefully on this need, and I think the entire committee is aware of the problem. I think we have clearly a commitment on the part of everyone from the chairman to the members that we will do something about this.

The CHAIRMAN. Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman. I just want to commend Senator Riegle for his efforts in this area.

I have had the personal opportunity to work with him in the Banking Committee on a similar kind of problem; namely, that of mortgage foreclosure. When he says that he wants a solution, that he is prepared to be flexible, that he is prepared to find any reasonable mechanism that will work, I know from my own personal experience that he means it.

He and I started from somewhat different positions on mortgage foreclosure, and we arrived at a solution that was not only acceptable to him and met my specific concerns but that garnered the support of a substantial majority of the members of the Banking Committee on a bipartisan basis. I think it was maybe something of a surprise to people to find that Republicans and Democrats could agree on something where there hadn't been much attention paid.

With "mortgage foreclosure," people were worried that it was going to give some kind of an incentive for people to foreclose, that it was a giveaway program, but we wrote a bill that was not a giveaway program, that doesn't give anybody an incentive to foreclose. In fact, it gives everybody an incentive to continue to engage in good lending and mortgage payment practices.

I think with that kind of a model of cooperation that we can find the same kind of cooperation here in this committee and make that kind of progress. I know the Chairman hopes for it as well—Chairman Durenberger and Chairman Dole.

Senator RIEGLE. I thank the Senator for his comments, and I think we are making progress.

I just want to thank all of you for the commitment of effort in this direction, because I think it is a critical national need, and our ability to respond to it is what helps people keep faith at a time—thinking now of the unemployed people and their families—when there isn't much hope out there for them at the moment.

I think this is one of the things that helps them understand that they are not forgotten and that they are not people who have been lost sight of. We are concerned about them, and we are going to respond here.

The CHAIRMAN. Right. I think there is a tendency to do that as we see signs of recovery, saying, "Well, the problem is going to go away." But I don't think it is really going to happen very quickly for hundreds of thousands of working people who just can't find work.

Thanks again, Senator Riegle, we appreciate it.

Senator RIEGLE. Thank you, Mr. Chairman.

The CHAIRMAN. We have a panel now consisting of Dr. Joseph Boyle, chairman of the Board of Trustees, and Jim Sammons who is a regular visitor, executive vice president of the American Medical Association; along with Dr. James Strain, president, and Don Blim, of the American Academy of Pediatrics in Arlington, Va.

I might say at the outset that your written statements will be made a part of the record. We would hope you might be able to summarize the statements, then I think we might have some time for questions.

Dr. Boyle, do you want to start off?

STATEMENT OF JOSEPH F. BOYLE, M.D., CHAIRMAN OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL., ACCOMPANIED BY DR. JAMES SAMMONS, EXECUTIVE VICE PRESIDENT AND HARRY PETERSON, DIRECTOR, DEPARTMENT OF LEGISLATION

Dr. BOYLE. Good morning, Senator.

I am Dr. Joseph Boyle. I am an internist practicing in Los Angeles. I am chairman of the Board of Trustees of the American Medical Association.

Participating with me this morning, as you have indicated, is Dr. James Sammons, the executive vice president of the American Medical Association; and Mr. Harry Peterson, who is the director of our Department of Legislation.

I had hoped you wouldn't insist we read the entire statement, and we will summarize it very briefly.

The CHAIRMAN. Thank you.

Dr. BOYLE. First of all, our association has recognized the fact that millions of people who are unemployed have lost their employment-based insurance coverage.

The studies that we are aware of indicate that the unemployed often need more medical services because of the stress involved with unemployment, and in addition, as others have indicated, people delay obtaining care, and as a consequence are in need of more intensive services when they do.

Many unemployed persons are able to participate in paying for some of their medical care, but many more cannot afford to purchase health insurance, and most of them do not qualify for Government assistance in obtaining medical care.

The American Medical Association has encouraged individual physicians, State and local medical societies, and national medical specialty societies to develop voluntary programs to provide health care to the unemployed and their families, and we are pleased to report that many have done so. As a matter of fact, in our recent survey, 71 percent of physicians in this country have provided care either at no charge or with a reduced charge to those people who have become unemployed, and there are about 10 percent of all physicians who are donating their services to a number of fair-share programs that have been set up by State and county and specialty societies all over the country.

The scope of the unemployment problem is such that we do believe that a temporary national program to provide health insurance for the unemployed is needed.

Dr. Sammons will continue with our statement.

Dr. SAMMONS. Good morning, Mr. Chairman, and members of the committee. Thank you for this opportunity, and we would extend our sincere appreciation, Mr. Chairman, to you and Senator Durenberger, Senator Riegle, and others, who have introduced legislation that has brought this matter now to the forefront before the Senate and before the American people.

We do indeed believe that the time has come when a formal federally initiated program for the unemployed in health benefits should be put into place.

Clearly, before you today are a whole series of options as to how one might best do that. Let us go on the record as saying we believe that this program should be temporary. Clearly, we share with the chairman the belief that the general economy is not by tomorrow going to turn upside down, and during the time in which it takes to do that, this program should be in place.

But it should indeed be temporary. It should have a limited scope. Indeed, we are not in a position in this country today to institute another Cadillac-care program when it is not necessary.

We share the point of view that not all unemployed need to be covered by this program, because there are other methods of covering some of the unemployed in the country.

We believe that probably the most effective mechanism to do this today is the unemployment compensation system. It is a system that is already in place; it does already have Federal participation; people who are unemployed are in that system, and the Congress itself has just extended those benefits, as you very well know, sir.

So we believe that the unemployment compensation system is a very appropriate vehicle to which this can be attached.

We share completely the concept that there should be some sharing of risk here. Both the Federal Government and the private sector should share in the responsibility for financing this program.

We believe that, again, the unemployment compensation system by virtue of its inclusion of the private sector, the employers of this country, is a very effective mechanism and a very appropriate mechanism to use in this regard.

We also would extend to the committee a great willingness to work with this committee as you and your staff go through ironing out the details of whatever the program is that comes out of these hearings.

We regret that the administration has not yet been able to give us the benefit of their thinking, and since we do not know what the administration is going to say, I suspect that we would be in great part at least sympathetic to what they will say, because I would expect the administration to share with us the belief that this does need to be done in the private sector.

We believe the insurance mechanism is appropriate. Insurance can be purchased through statewide pooling arrangements. All of these details can be handled by this committee, and we believe that the purchase of insurance, the use of a voucher system if need be for that purchase, through the insurance pools on a State-by-State basis is the appropriate way to go.

Now, I don't know whether the 4 percent is the correct number or not, and I don't really think it matters. The thing that does matter, it seems to us, is that there must be some trigger, whether your 4 percent is correct or a 2-percent, or whatever the number. I share with Mr. Bentsen, clearly, as an old Texan, his concerns about Texas. But nevertheless, we think that there must be a triggering mechanism—some percentage level or some formula that can be applied.

Certainly we do not wish to see this become another entitlement program, and without a trigger it would be.

We have grave concerns that it should not be tied to either medicare or medicaid, for that very reason.

Thank you very much, Senator.

The CHAIRMAN. Thank you very much.

[The prepared statement of Drs. Boyle and Sammons follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Finance
U.S. Senate

Presented by

Joseph F. Boyle, M.D.
and
James H. Sammons, M.D.

RE: Health Care and Health Insurance
for the Unemployed

April 21, 1983

Mr. Chairman and Members of the Committee:

I am Joseph F. Boyle, M.D., a physician in the practice of internal medicine in Los Angeles, California, and I am Chairman of the Board of Trustees of the American Medical Association. Participating in presenting this testimony is AMA's Executive Vice-President, James H. Sammons, M.D. Accompanying us is Harry N. Peterson, Director of AMA's Division of Legislative Activities.

The American Medical Association appreciates the opportunity to appear today to discuss the subject of health care and health insurance for the unemployed. We commend this Committee for holding these hearings to highlight this important subject and to seek resolution of a serious problem facing the nation.

The problem of health care and health insurance coverage for the unemployed is not new. The United States has not achieved full employment for decades, and there has been a substantial level of unemployment among Americans over this time. In fact, this is not the first time that this issue has been addressed by the Congress. In 1975, with national unemployment in the 8% range, legislation was introduced and major hearings were held on this very same subject. The American Medical Association at that time endorsed federal efforts for a short-term program to provide health benefit coverage for the unemployed. What is new, Mr. Chairman, are the high levels of unemployment facing the nation as a whole and in specific areas of the country where unemployment nearly doubles the national rate.

Furthermore, knowledgeable analysts indicate the average length of unemployment during this recession has increased and that it is expected that a significant number of individuals will not be able to return to their previous jobs even during a national economic upturn. This extended unemployment problem has been recognized by this Committee and the Congress through major extensions in coverage for unemployment compensation, including the recent extension of emergency benefits as part of the Social Security reform package. It has been estimated that

some 5.3 million individuals have lost their jobs and their health insurance coverage. Thus there are millions who face the loss of medical care coverage for themselves and their families--including their children who need regular medical supervision. Furthermore, recent studies indicate that the unemployed are often in need of more medical care due to the stress of unemployment. Mr. Chairman, we face a public health problem that must be addressed.

The effect of these economic circumstances can be widespread. During such times families must defer health expenditures, and they live in fear of incurring health expenses which may leave them in debt for an extended future period. Health care institutions are also affected and can be placed in serious fiscal jeopardy. Health insurance plans, faced with loss of membership, are less able to spread risks. There is an increasing impact across the entire health industry.

The current "crisis" relating to health insurance for the unemployed is a direct result of a very successful public policy that has encouraged employment-based health benefit plans. Approximately 90% of the non-farm U.S. workers receive health benefit plans through employer-based group policies, with their employer paying part or all of the premium. Therefore, when unemployment grows, the number of individuals who lose health insurance coverage increases.

Existing federal programs, including Medicare and Medicaid, provide specific health care benefits to targeted populations. State and local programs often provide health care services or coverage to those who do

not qualify for federal programs, such as Medicare and Medicaid, but generally such assistance is limited to those who are without assets or other financial means.

The newly unemployed person rarely fits into one of these categories. When income from active employment ends, these individuals usually have significant assets, such as homes, cars and furnishings, that preclude their participation in either Medicaid or state and local general assistance programs. Unfortunately, because of their loss of income and because of the higher cost of individual health insurance policies compared to group benefit plans, many unemployed individuals cannot afford to cover adequately the expected health insurance needs of their families. It is this group, then, that needs to be addressed. It is for this group that a bridge should be built to provide coverage for an interim period until the individual can become employed again and receive employment-based health insurance benefits.

For some time the AMA has been active in encouraging individual physicians, state and local medical societies, and national medical specialty societies to develop voluntary programs to ensure continuation of health care to the unemployed and their families who are in need of such care. Many physicians have assisted unemployed patients in meeting their health care needs. Seventy-nine percent of physicians surveyed by the AMA's Socioeconomic Monitoring System indicated that during October and November of 1982 they had treated patients who had lost their health insurance due to unemployment. Of those physicians treating patients who lost benefits due to unemployment, 71% provided care without charge or at

reduced rates. Furthermore, at that time approximately 10% of all physicians were donating their services to some type of "fair share" program organized by community leaders and medical societies to provide services for those who have lost their primary source of income and do not qualify for government assistance.

Recent information indicates medical societies and the health community have become more active in initiating programs to assist the unemployed. To date we have catalogued 23 formal programs sponsored by medical societies or hospital medical staffs to assist the unemployed in receiving medical care. For example, as early as June 1981, the Wayne County Medical Society in Detroit, Michigan, began recruiting physicians to participate in a task force to ensure the availability of health care services for the recently unemployed. This program covers physicians from Detroit and Oakland County, which are especially hard hit by layoffs in the auto industry. Another example is the Harris County Medical Society in Houston, Texas, which has a program under which physicians provide free care in their offices or work in a public clinic for a day. This program has the participation of over 1000 of the Society's members.

We are proud of these initiatives and are encouraging more and more societies and physicians to follow suit. However, the scope of the current unemployment problem and the length of the current recession indicate to us that a temporary nationwide program to provide health insurance for the unemployed is necessary. This is especially true in light of the structural unemployment problems now facing the nation.

Mr. Chairman, Dr. Sammons will now continue our statement and discuss our views on the direction that such a health insurance program could take.

STATEMENT OF JAMES H. SAMMONS, M.D.

Mr. Chairman, as during the 1975 recession, a number of bills have been introduced in Congress to provide health benefit coverage for the unemployed. These bills embrace a variety of approaches. Our Council on Legislation is now reviewing the various proposals, and we expect to have a more definitive response shortly. Nevertheless, it is appropriate to discuss options that are open to us as a nation. Governments at all levels are already financially strapped. A national program must not be self-defeating, i.e., it should not so increase the deficit structure as to impede economic recovery. The country's main objective must remain a return to a healthy economic condition. This is the main problem facing the unemployed. Together, however, we must find answers to a very real and serious problem affecting a significant number of our population.

Mr. Chairman, the AMA supports the creation of a formal program to provide health insurance coverage for the unemployed. In our view such a program should be based on certain basic principles:

It should have limited eligibility, targeted among the unemployed.

While government must have a role, the program should be administered in the private sector, providing private insurance coverage.

It should avoid disruption in continuity of care for the individual and his or her family and, to the extent possible, in continuity of health insurance coverage.

Financing should be a shared responsibility of government and the private sector.

It should provide benefits limited in scope, and provide for freedom of choice of providers.

It should be temporary and subject to early and ongoing Congressional and public review and evaluation.

I will discuss these areas in more detail.

Eligibility

Eligibility for such a program must be limited in scope. For quick adaptation it could be tied to some existing fixed standard, e.g., enbracing those individuals who have had employment-based coverage and who have a right to receive regular, extended or federal supplemental unemployment compensation benefits. For ease in identification, the state unemployment compensation system could be used to identify qualifying individuals.

There is no need to cover certain individuals even though they are unemployed. Individuals should be excluded if coverage can be obtained by another family member who is eligible for employment-based coverage or is eligible for continuation of an employer-offered health benefit plan. In addition, persons who are eligible for Medicare, Medicaid, or other government programs should be required to use such coverage. Stating this more generally, the new benefit should be secondary to other coverage.

Equitable coverage within restricted available financing will be difficult to achieve, but must remain our goal. To achieve this more

equitable coverage, individuals whose unemployment compensation benefits have expired should be grandfathered in. Nevertheless, some period limiting eligibility will need to be fixed.

Administration

A plan could be operated at the state level through the use of statewide insurance pooling arrangements or through the purchase of a policy by the unemployed individual using a voucher. All insurors, including the self-insured companies, would participate. Again, a state unemployment compensation office could be used as the focus for identification of eligibility and for the individual to receive information and assistance in obtaining coverage. Private insurance must be the vehicle for benefit coverage. This new program must not become enmeshed with Medicare or Medicaid. Caution must be expressed lest new troubles be created through expansion of an entitlement concept.

Financing

Payment for the coverage could come from varied sources. Unemployed individuals should be responsible for some portion of the cost of coverage and care up to a maximum amount or fixed percentage of income. This could be accomplished by adjusting the individual premium obligation to reflect family income and through income-related coinsurance, deductibles and stop-loss levels. The federal government should share in a program that is to have viability. Particularly where national unemployment exceeds a certain level and a state's unemployment rate exceeds a figure, say 110% of the national average, the federal government should contribute to the program. This federal contribution

would assist those states that are hardest hit by long-term unemployment. Employers should participate as well. The basic principle of unemployment compensation has worked well, and employers' contributions for health benefits through expansion of this system should be explored. Assistance to states through a block grant could provide federal assistance with flexibility in state management. Methods should be considered to encourage employers and those who are employed to extend employment based coverage in the event of lay-offs.

Benefits

If a program is to be viable, the benefit package must be keyed to financial feasibility. The premium must be reasonable in amount. Accordingly, the benefits must be limited. Nevertheless they should include critical services, such as inpatient hospital care, emergency outpatient hospital services, physicians' services, emphasizing outpatient services in a physician's office. Prenatal, maternity and postpartem care, as well as diagnostic, laboratory and radiology services, must be included.

Duration

In our view, any program created should be temporary. It should remain in place for a limited period of time with a sunset provision. Such a requirement would establish the need for Congress and the nation to reevaluate the continuation of or modifications to the program on a regular basis rather than creating another "untouchable" entitlement program.

Conclusion

Mr. Chairman, the American Medical Association has been actively involved in encouraging our members and other medical societies to provide health care for the unemployed. These activities will continue. However, the scope of the problem, along with the expected duration of high levels of unemployment, indicate a need for a more formal and comprehensive way of dealing with this temporary situation. We urge the Committee to structure any program to encourage the use of the private sector, both in insurance underwriting and service delivery. Use of the private sector will avoid disruption of existing relationships among patients, physicians, insurors and providers, thereby allowing for continuity of high quality care for families during the temporary period when an individual is unemployed.

We recognize the many problems facing this Committee as it considers this subject. We will continue our analysis of the various legislative approaches before the Congress and will be pleased to offer our assistance in seeking an appropriate resolution of this serious problem.

Mr. Chairman, we would be pleased to answer any questions the Committee may have.

0866p

The CHAIRMAN. Dr. Strain.
[The prepared statement of James E. Strain follows:]

TESTIMONY

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ON

HEALTH INSURANCE FOR THE UNEMPLOYED

PRESENTED BY

JAMES E. STRAIN, M.D., PRESIDENT
AMERICAN ACADEMY OF PEDIATRICS

APRIL 21, 1983

Mr. Chairman, members of the Finance Committee, my name is James E. Strain. I am a practicing pediatrician in Denver Colorado, and President of the American Academy of Pediatrics. Accompanying me is R. Don Blim, a practicing pediatrician in Shawnee Mission, Kansas, a past president of the Academy.

We are pleased to have the opportunity today to testify on the problem of medical care for the unemployed. Loss of health insurance is a serious and intractable problem, and you are to be commended, along with your colleagues, for proposing some practical and necessary solutions. Members and Fellows of the American Academy of Pediatrics across the country are acutely aware of the problem and are already engaged in efforts to help care for these children from unemployed families.

This is as it should be and, indeed, as it always has been. Pediatricians know well that children are the most vulnerable segment of our population even in the best of times. They are often the first to suffer, of course, when so many people lose their jobs. We believe that children should receive the highest quality of care, and that whatever actions are needed to provide this care should be taken.

As a result of the depressed economy today, more and more families now must pay directly for the health care services their children need. This is painfully and particularly true of young families -- they bear the brunt of lay offs since younger employees are generally among the last hired and first fired. In more favorable circumstances, hospitalization and serious illnesses that children incur are covered by the health insurance plans. Yet the essential preventive medicine and health maintenance services are not. Working families generally can find a means to pay directly, but when lay offs have reduced their income, it is most difficult to set aside funds for children's preventive health care.

Many unemployed parents are too proud or embarrassed to ask physicians if special

arrangements can be made for the children's health care. As a result, as president of the American Academy of Pediatrics, I have urged pediatricians to take the first step and let unemployed families know that he or she -- the pediatrician -- is sympathetic to their problems. I have asked them, where necessary, to make arrangements for deferred payments or in some cases to provide free care. Pediatricians know that these are especially difficult times demanding sacrifices from all of us, and they are responding as appropriate in many areas.

Mr. Chairman, the problem for children is lost coverage for hospitalization as well as physician services, and S. 951 would provide a remedy for those families eligible for unemployment insurance by assisting the states in providing for their coverage. This measure permits the states to require beneficiaries to pay deductibles and coinsurance, but it correctly excludes any deductibles or coinsurance with respect to prenatal or postpartum care. The states' Medicaid administrators would operate the payment mechanism for this program as well. But we would like to see another Medicaid feature incorporated as a provision in S. 951. Medicaid, as opposed to private health insurance, includes essential services for children. These are the early and periodic screening, diagnosis and treatment services (EPSDT), which help to prevent illness and to detect problems before they become serious. Private health insurance in a defective, inequitable and discriminatory fashion, typically excludes these types of services.

Once again, Mr. Chairman, we wish to commend you and your colleagues for your leadership and dedication to problem-solving in proposing legislation to assist unemployed working people in meeting the cost of health care for their children.

We would be pleased to respond to your questions.

STATEMENT OF JAMES E. STRAIN, M.D., PRESIDENT, THE AMERICAN ACADEMY OF PEDIATRICS, ARLINGTON, VA.

Dr. STRAIN. Mr. Chairman and members of the Finance Committee, my name is James E. Strain, and I am a practicing pediatrician in Denver, Colo., and president of the American Academy of Pediatrics, an organization of about 25,000 pediatricians.

Accompanying me is Dr. Don Blim, a practicing pediatrician from Shawnee Mission, Kans., a past president of the Academy.

We are very pleased to have the opportunity today to testify on the problem of medical care for the unemployed, especially as it relates to children.

We are very supportive of S. 951. Loss of health insurance is a serious and intractable problem, and you are to be commended along with your colleagues for proposing some practical and necessary solution.

Members and Fellows of the American Academy of Pediatrics across the country have been concerned about the unemployed families and have already engaged in many efforts to help in the care of these children. This is as it should be and has always been.

Pediatricians know that children are our most vulnerable segment of the population even in the best of times. They are often the first to suffer when people lose their jobs. We believe that children should receive the highest quality of care, and that whatever actions are needed to provide this care should be taken.

As a result of the depressed economy today, more and more families now must pay directly for the health care services that their children need. This is particularly true of young families. They bear the brunt of the layoffs; they are the last to be hired and the first to be fired.

In more favorable circumstances, hospitalization and serious illnesses that children incur are covered by health insurance plans; yet the essential preventive medicine services and health maintenance services are not. Working families generally can find means to pay directly, but when layoffs have reduced their income it is most difficult to set aside funds for children's preventive health services.

Many unemployed parents are too proud or embarrassed to ask pediatricians to make special arrangements for their children's health care, and as a result, as president of the Academy of Pediatrics, I have urged pediatricians through our national publications to step forward and let unemployed families know that he or she, the pediatrician, is sympathetic to their problem.

I have asked them, where necessary, to make arrangements for deferred payments, for reduced payments, or in some cases to provide free care. Pediatricians know that these are especially difficult times that demand sacrifices from all of us, and they are responding in appropriate ways in many areas.

However, it is clear that even though pediatricians in many instances provide services without charge, the matter of cost for hospitalization is still an unresolved problem in a voluntary effort.

Mr. Chairman, the problem of children is lost coverage for hospitalization as well as physician services for acute care, and S. 951 would provide a remedy for those families eligible for unemploy-

ment insurance by assisting the States in providing for their coverage.

This measure permits the States to require beneficiaries to pay deductibles and coinsurance, but it correctly excludes any deductibles or coinsurance with respect to prenatal or postnatal care.

The States' medicaid administrators would operate the payment mechanism for this program as well, but we would like to see another Medicaid feature incorporated as a provision of S. 951, specifically, the EPSDT services.

Medicaid, as opposed to private health insurance, includes essential preventive health services for children. These are the early and periodic screening, diagnosis and treatment services, the EPSDT, which help to prevent illness and to detect problems before they become serious. Private health insurance is defective, inequitable, and in many instances discriminatory, because it typically excludes these types of services which children need.

Once again, Mr. Chairman, I wish to commend you and your colleagues for your leadership and dedication to this problem-solving in proposing legislation to assist unemployed working people in meeting the cost of health care for their children.

We would be pleased to respond to any questions.

The CHAIRMAN. Dr. Blim, do you have any comments?

Dr. BLIM. Only on a personal note.

I have a patient at the present time that is 3 months of age. Through the result of health supervision, her liver illness was detected. She is in the hospital at the present time and will be in the hospital for approximately 3 weeks.

Ultimately we are planning to send her to the University of Minnesota for a liver transplant, but at the present time she is the daughter of an unemployed motors worker. Kansas City I think is second to Detroit in the motors industry and has a significant amount of unemployment. At the present time her care is being financed—her father has lost his health insurance benefit, and the care is being financed as a result of a public effort in the community to raise money for her illness and for her subsequent care.

So I would just echo Dr. Strain's comments.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Thank you very much, Dr. Blim.

Well, the University Hospital and Dr. Najerian are getting famous for starting community drives all over the country for liver transplants.

Let me thank the Academy and Dr. Strain for his comments, particularly putting the focus on the new parents. The new parents are, in the employment sector, the last hired and the first fired, and we have just got to keep that in mind all the time, because too often we think of the tragedy of unemployment in terms of someone who has been working for 20 years and it's his first layoff or first unemployment. But from our standpoint, this is a terribly serious problem.

Another point of clarification: The trigger has come up again as it did twice from Senators. I think we need to make a point, though, with regard to our legislation. The 4-percent trigger as it's called applies to the title XX allocation only. It doesn't mean we aren't going to have this program in a State or make it available to

a State that has 1-percent unemployment. You can still use the mechanism of this legislation. It is only the proposal for the $750 million supplemental allocation out of title XX that falls in that trigger category. And at least as far as we can tell, that's somewhere in the neighborhood of 19 or 20 percent of the costs.

So it isn't as though the whole program that we have proposed is hung on this 4-percent IUR trigger. Jim, let me ask you maybe just one question that is significant. As I heard the testimony of the AMA, your advice to us was to keep it temporary, use the UC system, make sure the risk-sharing is between the Government and the private sector, but please try to put the emphasis on the private insurance side with the pooling arrangement.

I assumed when you talked about risk-sharing you included the consumers in your concept of risk-sharing as well, even though you didn't say it.

Dr. SAMMONS. Well, indeed we do. And I think the term that you have been skirting this morning, or trying to find this morning, is affordable. It must be affordable in terms of the participation of the unemployed; otherwise this program would be self-defeating.

On the other hand, if there is not a risk-sharing, then clearly the program is not going to accomplish the sorts of goals that you would like to have it accomplish, that we all would.

The basic financing mechanism, as we see it, can in fact be done through the unemployment compensation system, and you will have Government at all levels as well as the employers who will be involved, and you can add an affordable risk-sharing on the part of the recipient. Absolutely.

Senator DURENBERGER. Well, in part that depends on the benefit package, and Dr. Strain has suggested we add to the benefit package we have proposed EPSDT.

Do you have a position in terms of the benefit package as proposed that might suggest we add or delete anything?

Dr. SAMMONS. Unfortunately, these hearings caught us a little by surprise. If you had waited 3 weeks or 4 weeks for these hearings, I think we could have given you a pretty comprehensive set of benefits to look at.

Senator DURENBERGER. Well, that's great, because the last time you were here you said, 'If you could give us a year—" [Laughter.]

So we've made great progress.

Dr. SAMMONS. We make progress slowly, Senator. [Laughter.]

But we are making some progress with that, and as I said earlier, we will be happy to work with Sheila and her people and with the members of the committee.

I think you have to have limited benefits. People who are in the category of the unemployed, for example, certainly don't need long-term care benefits as the elderly would need long-term care benefits.

We share with the pediatricians a very grave concern here. Mothers, expectant mothers, postpartum mothers, and children of the unemployed have got to be protected—there is no question. And in the process the unemployed individual, if a man, must also be protected.

But at the same time, because of the differences in age and in relative states of health, there are limitations that can be imposed

in these packages without interfering with quality medical care, and without depriving individuals of needed medical care.

You do not have to have a Cadillac-set of benefits. at the same time, you can certainly protect them without that.

Senator DURENBERGER. My last comment or question—and this may come as a surprise—obviously it is not my intention, at least, to design a new Federal program. And this is a matter of clarifying terminology here. I see our role mainly as facilitating programs that will be available in the private sector or at the State level. This is in effect a State program.

We are setting up in part a Federal financing mechanism for a portion of it, but we would like to see these be State-based programs, at least in the interim, until they might be private programs or some combination.

And I think it is our view that different States may set the programs up in different ways, and they may contribute different amounts to it.

Do you find any problem with that? Not having a so-called standardized Federal program the same all over the country?

Dr. SAMMONS. No. As a matter of fact, we would share with you the point of view that the Federal role should be limited; but I think it is terribly important that there be a Federal role.

If there is not a Federal role in seeing to it that these programs are put into place, and clarifying the mechanism by which they will be financed as well as administered, then we will have chaos in the system. The extent to which the individual States are able to participate clearly is a reflection of their own economy; on the other hand, basic benefits and a set of structured basic benefits to provide uniformity to this program, in our view, is badly in need and will be very necessary.

We would share with you, Senator, the concern about the use of the insurance industry. There is no reason for the private insurance industry in this country not to be the participant in terms of providing the coverage and the vehicle for pavment for that coverage. Indeed, that is exactly the basis on which we recommend the statewide pools and the purchase of insurance through those pools by the appropriate authority for these individuals who are unemployed. Absolutely.

Senator DURENBERGER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Durenberger.

I think you have probably answered the question. I certainly want to commend the physicians in every State of this Nation for their willingness—as you have indicated, some 70 percent are now in the process of providing free care.

But again, as pointed out by Dr. Strain, we've got the other problem of the hospital costs, and that leads I guess to what Dr. Blim has referred to as maybe a public effort to take care of one case. And if we multiply that by thousands, I assume that there is a responsibility that must be addressed.

It was sort of implied in a headline yesterday in the Washington Post—and I know the writers of stories don't write the headlines—that the AMA could just handle this thing by itself. But you have indicated this morning rather clearly that you do see a Federal

role, a limited role, and you don't share the view expressed in the headline.

Dr. SAMMONS. Mr. Chairman, I thank you for raising the question. We would like to put into the record a letter that Dr. Rial has written to the editor of the Washington Post to clarify that writer's misinterpretation of what was said.

Indeed, we do recognize that there is a need for the Federal Government to be involved, that there is a Federal role, and that this is the appropriate committee in the Senate to have the jurisdiction in that determination.

With your permission, I would like to add this to the record.

The CHAIRMAN. Right. We don't worry about headlines, ourselves. As long as somebody else makes the headlines, we don't worry about them. [Laughter.]

We didn't know doctors had that concern, but we are pleased that they do have. And I will be happy to make that letter a part of the record. I hope that it may appear in the Post sometime.

Dr. SAMMONS. We do, too.

The CHAIRMAN. If not, it will be in our publication—which is widely read. [Laughter.]

[The letter from Dr. Rial to the editor of the Washington Post follows:]

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 910 221 0300

PRESIDENT
WILLIAM Y. RIAL, M.D.
111 Dartmouth Avenue
Swarthmore, Pennsylvania 19081

April 20, 1983

Editor
The Washington Post
1150 15th Street, N.W.
Washington, D.C. 20071

Dear Sir,

The April 20 article on the work that physicians are doing to provide free or low-cost care to the unemployed who have exhausted their health coverage gave the impression that I did not believe that federal involvement was necessary to help to cover the long-term costs of care, particularly hospital care and care for those unemployed due to the changing structure of our economy.

The quote attributed to Dr. Coury, Vice-chairman of the AMA Board of Trustees, reflects my views on this subject. Dr. Coury stated, "We recognize that the federal government has to have an increased part, no question about it. We also think it has to be a joint effort between industry and government and the physicians."

Sincerely yours,

William Y. Rial, M.D.
President

WYR:ehf

The CHAIRMAN. I think maybe Dr. Strain indicated EPSDT was a priority, and I was going to ask you that question. You know, Senator Durenberger, and others, and everybody on the panel knows that we have very limited resources. The budget committee is meeting right now and has so far been unable to come to an agreement on anything in an effort to put a budget resolution together.

Where should we place our priority with respect to services for children? You may have outlined that in your statement.

Dr. STRAIN. Well, the reason we think that EPSDT should be included is that we really think that is a cost-effective program. It is a preventive health care program that in the long run I think saves money.

We have some good documentation of the reduced utilization of hospital services, and the cost of care of serious illnesses, by using preventive health services. And that's the reason we think that a major emphasis should be put on EPSDT.

The CHAIRMAN. You also mention in your statement about some existing discrimination against children in private health insurance. And again, if you have outlined that with more detail in your statement——

Dr. STRAIN. Well, we can certainly get you more details about that. It is true that most health insurance in the private sector does not include children. Most of children's services are ambulatory; they are in the physicians' offices. They are not covered by the traditional health insurance programs.

So we feel that there should be a reorientation of health insurance coverage to include the services that are provided in the ambulatory setting, and we will be glad to furnish you with the information we have in that regard.

The CHAIRMAN. I am just wondering as a matter of information—even though you have all these physicians, 70 percent or more and probably higher in some areas, providing all of this service, how do they deal with the hospital end of it? I mean, the meter is still running in the hospital. Has that been a problem for physicians who provide free care, but you don't have access to free hospital care?

Dr. STRAIN. Yes, Senator Dole. In many, many instances the hospitals have participated as well in providing care for people at no charge. That becomes a part of their bad debt, and it then becomes a part of the burden for which other people have to pay. We believe that in addressing this problem that you have taken the correct approach, and that is one in which everybody should share in the solution of a problem that affects all of us.

Physicians are certainly willing to participate to the degree that they have already; we believe that hospitals should be involved, and we believe that the insurance industry should be involved, and we believe that the pharmaceutical industry should be involved. Everybody should have a part of trying to provide a solution.

We know that you are searching for details, and we would very much like to work with you and your committee and staff in approaching this solution.

The CHAIRMAN. Right. And I think once we have the administration's views it will be helpful to all of those who may be here today. I know we don't have the views now, but I know they are in

the process of trying to determine a position—again, based on the budgetary constraints and the need in it.

I want to indicate, as Senator Durenberger has, that the last thing we are trying to do is to create a new entitlement program. Now, there are some around who would like to do that. In fact, there are already some seeds being planted on the other side of the Capitol. But that is not the intent of this committee.

We recognize that it should be short term. It's more or less of an emergency problem, and that's why we want to address it as quickly as we can.

I think Senator Specter is correct, and others are correct. There is a need now, and it's been there for some time. We haven't addressed it, and we should.

So if you can be helpful as we move rather quickly, it would be appreciated. Does anyone else have anything he wants to add?

Dr. SAMMONS. Just one additional comment, Mr. Chairman. We have recommended in our full statement that you include in this proposal outpatient benefits—in the physician's office, in the ambulatory setting—to resolve the problem which has been clearly brought to focus this morning.

That's the most cost effective to render the care, in the doctor's office. And the children as well as adults need that protection in this particularly difficult time. You will find that in our full statement as a recommendation

The CHAIRMAN. Thank you very much.

Dr. SAMMONS. Thank you very much, Mr. Chairman.

Dr. BLIM. Thank you.

The CHAIRMAN. We appreciate your coming, in most cases long distances, and thank you very much.

Mr. SAMMONS. Well, thank you for the opportunity. We appreciate being a part of this hearing.

The CHAIRMAN. Our next panel: Mr. Jack Owen, executive vice president of the Washington Office, American Hospital Association; Larry Gage, president of the National Association of Public Hospitals.

Jack, do you want to start off?

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, WASHINGTON OFFICE, AMERICAN HOSPITAL ASSOCIATION, CHICAGO, ILL.

Mr. OWEN. Thank you, Mr. Chairman. I am Jack Owen, executive vice president of the American Hospital Association and director of the Washington office.

I appreciate the opportunity to be here today, and I apologize that we do not have a written statement. We will try to get that to you very quickly. I think the people in Chicago may have been reading megatrends too long, and they think nothing happens in Washington.

The CHAIRMAN. Well, it doesn't happen very often, but occasionally, even by design.

Mr. OWEN. We do appreciate the promptness with which this subject has been addressed, Senator Dole, and you are right—the

emergency has been there, and now is the time to do something about it.

Just quickly going through some comments that I would like to make this morning:

You well know the problem. There are some 12.4 million Americans out there who are unemployed, and statistics show us that 1 out of 8 are going to be hospitalized during the next year. That's a lot of people who are going to end up in our hospitals.

We think as well as you do that the short-term problem is probably going to extend through a few more years, but we think it is time now to get at the whole situation.

One of the problems that we discovered in the unemployed is that most of the work force, in fact about 90 percent, have health coverage which is paid for by their employers. And when they lose their jobs they do not have any access to health insurance, and they find themselves without any protection.

We don't think the problem is one of access—there is health services available to these people—but rather the cost of such access to care.

When unemployed workers find that they are out of a job and their employer is no longer paying their premiums, the cost of the premium out of their unemployment contribution is just too much, so they can't afford it. There are too many other necessities.

I think you have a sensible approach of participation, because we believe there have to be beneficiary incentives as well as hospital incentives, and this may be a good way to approach this.

Senator Durenberger mentioned this morning that hospitals have always had the problem of taking care of the poor, and we will continue to have them. I don't think this bill is going to solve all of those problems nor is it intended to.

The problem that occurs—and I think Senator Riegle pointed it out so well—is that hospitals, in taking care of the poor, know that they have got a certain amount that they have to take care of. And when a situation comes along where we have high unemployment and get a large number of those uncovered by health coverage in an area, it puts a burden that is too much for the hospital to bear. I think some of the hospitals in Michigan are on the verge of bankruptcy because of this amount of free care now being required of them to give.

I would like to comment very briefly on free care and just state that there is no such thing as free care. I mean, we use that term pretty glibly in this field, and there isn't anything in the hospital that is free. We have to pay for the medicines, we have to pay for the nursing care and the fuel we use and the food, and all those other things. So somebody has to pay for it; it's not free.

We feel without some additional public and private effort, that many people are going to postpone some needed care, and particularly in the preventive and prenatal services. I was pleased to hear Dr. Strain bring that up, because we find that there are some increases in infant mortality rates in areas of high unemployment, and we are also concerned about the increase in the diseases that deal with stress where there is unemployment. I think that is perfectly understandable. Where a person does not have employment, and he is concerned about that, his health begins to suffer. For

those who are taken care of in that area, and taken care of today, we are going to lessen the costs in the future if we can take care of them.

Now, there has been some talk about a hospital's effort to absorb these unemployed workers in need of care as part of their community-wide efforts, and we have heard about the physicians, and business, and labor, and we feel strongly that Federal legislation should be targeted to encourage these local programs.

I would just like to talk about a couple of them to give you an example of what the hospitals are doing, as you have heard about some of the physicians. I will just cite a few of them:

The Guthrie Clinic of Sayre, Pa., offers unemployed residents of a 2-county area a 50-percent cash discount on any of the clinic's 4 satellite facilities. This program has served about 250 persons since this past November.

There is a free health-care screening that is offered by Canonsburg, Pa., General Hospital 1 day each month. Fifty people were screened at the first clinic in February, and they have a 4-month waiting list of jobless workers and their families.

One of the most common types of medical services needed by the unemployed is maternity care, and there are 11 hospitals in the Portland, Ore., area which are offering prenatal and postnatal care to the unemployed.

In Detroit, Project Health Care in Detroit is a cooperative locally based task force that provides information and referral service to enable the unemployed to obtain physician and hospital care at a reduced or no charge, and it monitors the financial status of participating providers to insure that the caseload is equitably borne among them. This program began 18 months ago and has already served 1,400 patients.

I think what I really would like to stress with those examples is that, as Federal money is needed, and we know it's needed, we've got to allow for these programs to continue and not have a program which will put them out of existence or discourage them from continuing.

I think there are about five things we would like to see in the legislative guidelines:

First, public and private sector responsibility. I think the Federal effort should not create a regulatory structure which would substitute State and local government or private sector initiatives.

We think it should be flexible.

We think the eligibility should cover as many unemployed as possible.

And we do think the Federal funds are needed. We can't work without it.

And we think the benefit structure should be laid out very carefully.

I will just close by saying that with the medicaid-based approach, which is not starting a new system—I understand what you are trying to do and applaud you for that—we would strongly advocate the establishment of some kind of a waiver authority that would permit the States to implement experimental or alternative mechanisms to assist. We don't want to get bogged down in some regula-

tory procedure which will stop what has already taken place, but recognize the mechanisms there.

We, again, would encourage a sunset provision in order to avoid encumbering States with long-term obligations, and, second, because it requires us to go back and look at the program after a period of a couple of years. I think that is really necessary.

Thank you very much for the opportunity to be here, and I will be happy to answer any questions you might have.

The CHAIRMAN. Thank you, Mr. Owen.

Mr. Gage.

STATEMENT OF LARRY GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, WASHINGTON, D.C.

Mr. GAGE. Thank you very much, Mr. Chairman, Senator Durenberger.

On behalf of 40 of the Nation's largest public hospital systems around the country I am happy to have this opportunity to testify on a subject that we have been trying to talk about since the association came into existence with just five members 2 years ago. In fact, this has been one of our very most important issues

My prepared testimony which I have submitted for the record makes three principal points.

First, I wanted to remind you, at least in the prepared testimony, of who we are and what we do. Public hospitals are the hospitals of last resort. We have open-door policies, and we do not turn away patients for any reason. We are not part of the hospital cost problem. We have inflated at a full 5 percentage points less than the rest of the hospital industry. We have significant local funding—over 30 percent on average for all of our members. And we have a significant capacity for both ambulatory and specialized services for unemployed patients and all others.

The second part of my testimony comments on some of the recent discussion regarding private sector involvement. And indeed it is a welcome involvement from our point of view.

We believe it is admirable that representatives of the private health sector—physicians, private hospitals, and so forth—have come forward in recent weeks with plans to provide services free or at a reduced rate to the unemployed. We believe these are essential efforts to augment the needed Federal involvement.

We think Dave Stockman is wrong, however, to think volunteerism alone can meet the health needs of the unemployed, and we believe your legislation is badly needed.

At the suggestion of your staff we have surveyed a number of our members in the past week, trying to find areas or projects which have developed in the private sector or in concert with public hospitals to take care of unemployed people, and as a result of that survey we seriously question the extent to which the admirable recent rhetoric you have heard about organized private sector assistance has yet really translated into services for the unemployed.

We turned up, after surveying over a dozen of our members, two or three areas where there are significant projects underway. We note Flint, Mich., with the second highest local rate of unemploy-

ment in the country, seems to have a pretty good local project funded by the Stewart Mott Foundation. And there seems to be an effort in Cleveland, Ohio, which is admirable as well.

In the rest of the areas we surveyed—and these are set out in the testimony—we found virtually nothing. To be sure, the survey was limited to areas where there are public hospitals. In such areas the pressure is clearly lessened for rhetoric or action among private physicians or hospitals.

The programs cited by Jack, and also in other news stories this week, which appear to be successful are frankly in metropolitan areas, such as Pennsylvania, Portland, Oreg., and northern Virginia, where no public hospitals exist.

There is another element of our survey that I want to report on today. I was unprepared for the responses of several of our hospitals when I telephoned them around the country this week, not at the lack of private sector involvement, but at the tremendously increased bitterness and hostility they seem to be encountering.

In many instances they have received phone calls or letters repeatedly from private physicians or hospitals demanding assurances that all transferred patients would be served. In others, private emergency rooms have been closed and signs posted demanding large deposits.

For every local story, in other words, Mr. Chairman, of the private physician who compassionately continues to serve his newly uninsured and financially strapped patient, there are other stories of the door slamming shut.

I say this not to be devisive, but I don't want that picture to be entirely a rosy one as you sit here and listen today.

In Bakersfield, Calif., our public hospital member reports that one private hospital has gone so far as to print maps and instructions for uninsured patients, directing them to the county hospital. There is 14.9 percent unemployment in Bakersfield, Calif.

In response to this trend I would like to take this opportunity to make just one clear point to our unemployed citizens, and secondarily perhaps to private hospitals and this committee: No matter what funding decisions are made in the Congress or by the States regarding additional support, where public hospitals continue to exist they will use every available resource to keep their doors open.

Some of you may be unfamiliar with or perhaps suspicious of the quality of health care rendered in public hospitals in our Nation's cities today. Do not mistake the occasional lackluster shabbiness of the facades or the shortcomings of the hotel-type amenities with a lack of quality or dedication on the part of the physicians and the professional staff.

Let me suggest one fact which may help reasssure the unemployed patient: In virtually every major American city it is the public hospital which has been designated as the President's hospital when he is traveling in that area.

So do not deny yourselves needed care simply because you've lost your insurance. To you and the rest of the health care industry we want to make clear that we will uphold our commitment. I do have a number of comments on your legislative proposal. We strongly support this proposal. The general thrust of it and many of its par-

ticulars were part of some of the recommendations we have been making for the last 2 years.

I have a number of specific comments and recommendations to make which are contained in my prepared testimony. I will summarize those very briefly in closing my statement:

First, we are concerned about the administration of this program exclusively through States. We are aware there are States with tremendous fiscal problems out there, and there are some States which may, because of the modest additional costs involved, not to set up such a program.

Second, if they do establish a program, there may not be sufficient controls.

We believe that you should write into your bill at least the opportunity, in a State which does not choose to enact a program, for a local unit of government with high levels of unemployment to apply independently for funding.

We also believe you should write in a tough maintenance-of-effort provision to prevent States from simply using a program like this as a windfall to replace funds currently spent on other health care activities and programs.

Finally, we believe you should adopt an amendment consistent with the provisions you have adopted in other bills, requiring special considerations of the needs of public hospitals and other providers already serving substantial numbers of uninsured patients.

We are concerned that, while this program doesn't create a long-range entitlement, it does create an entitlement of sorts. Anything which enrolls individuals in a program is an entitlement. In the public hospital sector it may be the old charity model, but we are institutions who are budget-managed prospectively, and we keep our doors open. And that's the way we provide services. And with your limited funds, we do want to have the opportunity to have services provided as efficiently as possible, so that your $750 million goes as far as it can.

Third, we are concerned about some aspects of the benefit package, and some of the previous witnesses have mentioned this problem. In particular, we are very concerned about the appropriate definition of an emergency, that it not be unduly narrow. Frankly, one of the problems I think we are seeing in unemployed people today is that they are postponing needed care because they believe it's not an emergency, until it becomes virtually life-threatening, and we want to try to avoid that.

We think that the stricture against drugs and biologicals, except on an inpatient basis, should be viewed carefully, particularly with necessary drugs—asthmatic drugs, chemotherapy—which can be administered on an outpatient basis and which will be much more expensive for this program if hospital admission is required.

We do endorse the need to be especially sensitive to maternal and child health care, the prenatal care issue raised earlier by others.

Finally, in terms of determining eligibility, we believe, except for simply informing the State of the eligible individuals, that use of already burdened State employment services is entirely inappropriate, particularly to enroll individuals. Whether it is the State medicaid operation or some other health administrative apparatus, gen-

erally many people are enrolled for the first time in programs when they come in on their backs to the hospitals and we want to see some flexibility in this area as well.

I thank you very much, and I'll be happy to answer any questions you have.

[Mr. Gage's prepared statement follows:]

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STATEMENT OF LARRY S. GAGE, PRESIDENT,
NATIONAL ASSOCIATION OF PUBLIC HOSPITALS,
BEFORE THE SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE
UNITED STATES SENATE

April 21, 1983

Mr. Chairman, members of the Subcommittee, I am Larry Gage, President of the National Association of Public Hospitals. On behalf of the 40 public hospitals and hospital systems around the country which now comprise the membership of our Association, I appreciate this opportunity to testify today on the subject of meeting the health needs of unemployed Americans who have lost their insurance. Our member hospitals serve as the health safety net for all uninsured persons in many of our nation's metropolitan areas today. On several occasions they have singly or collectively urged your serious attention to this problem in the last year, and we are thus pleased to have this opportunity to work with you on some possible solutions.

In my testimony this morning, I would like to cover three major areas:

First, I would like briefly to describe the situation of public hospitals today, and to underscore for the Committee the important and unique role public hospitals continue to fill, with particular attention to the services they continue to make available to all uninsured persons, regardless of their severity of illness or ability to pay.

Second, I would like to share with the Committee the results of an informal survey we have conducted, at the request

of your staff, of NAPH member hospitals in areas of high unemployment, to determine what special public or private sector efforts are currently being undertaken to assist the unemployed; and

Third, I would like to express strong support for the legislation you have before you today and make several comments and recommendations about some of its specific provisions.

The Situation of Public Hospitals Today

Several NAPH members have described our nation's health safety net in some detail in previous testimony before your Committee. However, I believe it is appropriate in the context of this hearing to call your attention again to several key elements of our segment of America's health system -- and particularly, those which make public hospitals a unique and important asset in any program seeking to provide needed health services to our unemployed citizens:

- o PUBLIC HOSPITALS CONTINUE TO TAKE ALL PATIENTS -- REGARDLESS OF ABILITY TO PAY. Where public hospitals exist, they are "de facto" national health insurance today. Data collected by the Urban Institute showed that just 15 of the largest public hospitals in the country provided $597 million in non-Medicaid charity care in 1980 alone. "Charity care" comprises over 30% of the budget of the average public hospital -- as opposed to about 3% on average for the private sector.

- o PUBLIC HOSPITALS ARE NOT PART OF THE HOSPITAL INFLATION PROBLEM. NAPH data compiled last year showed an average annual inflation rate for public hospital budgets of just 9.8% per year between 1976 and 1980, as opposed to 14.7% for the hospital industry as a whole. New data we are compiling this year indicates that this historical gap continues to exist -- and indeed in some areas, is widening. In California in 1981, for example, all hospital costs increased 17.9%, while public hospital costs increased by just 10.3%.

- o DESPITE THE PERSISTENT WASHINGTON, D.C. MYTH THAT CITIES AND COUNTIES ARE NOT PAYING THEIR WAY, A SUBSTANTIAL PORTION OF THE PUBLIC HOSPITAL BUDGET COMES FROM LOCAL TAX REVENUES. NAPH data shows that 31% of our members' budgets come from local appropriations, as opposed to 22% from Medicaid and 16% from Medicare. Of $2.07 billion in total revenues received by just 23 public hospitals in 1980, $709 million were from state and local non-Medicaid appropriations. Nor do public hospitals in general have many private patients to whom costs can be shifted -- just 12%, on average, among NAPH members around the country.

- o PUBLIC HOSPITALS HAVE MANAGED THEIR RESOURCES EFFICIENTLY. A recent study by Alan Sager indicates that public hospitals have experienced the largest decrease in length of stay,

and the only increase in occupancy rate, among all classes of hospitals in the nation's 52 largest cities. Moreover, public hospitals have decreased their total number of beds between 1970 and 1980 -- by over 22% -- in those cities. In addition, most public hospitals are already managed and budgeted prospectively each year, with full, independent review by State and local governmental entities. Finally, such hospitals are often fully integrated institutions with salaried medical staff, and thus do not present many of the potential problems recognized recently by this Committee in separating hospital costs from physician costs.

- o THE NON-MEDICAID UNINSURED CASELOAD OF PUBLIC HOSPITALS HAS SUBSTANTIALLY INCREASED IN THE LAST YEAR. The newly unemployed comprise just one part of the increased indigent caseload of public hospitals in metropolitan areas. The problem is substantially exacerbated by reductions in Medicaid eligibility, and inadequate funding for special populations such as illegal aliens and refugees. Moreover, we believe we can also anticipate a significant increase in more severely ill Medicare patients, as private hospitals move to adjust their caseload to maximize reimbursement under the new DRG system.

o PUBLIC HOSITALS ARE IMPORTANT PROVIDERS OF PRIMARY AND AMBULATORY CARE TO POOR PERSONS WHO OFTEN HAVE LITTLE OR NO ACCESS TO PRIVATE PHYSICIANS. Just 23 of NAPH member hospitals had 5,254,839 outpatient visits and 2,150,855 emergency room visits in 1980 alone. A new, as yet incomplete survey of NAPH members' current experience in providing outpatient care indicates the following level of activity:

	1982 OPD/ER Visits
Bronx Municipal Hospital	588,037
Westchester County Medical Center	79,740
Seattle Public Health Hospital	112,602
Bellevue Hospital	522,719
St. Louis County Hospital	62,597
L.A. County/USC Medical Center	400,809
Highland General Hospital (Oakland)	108,843
King/Drew Medical Center (Los Angeles)	184,843
University Hospital/Newark	130,232
Cook County Hospital	584,208
Parkland Memorial Hospital (Dallas)	411,387

In many cases, these figures represent a substantial increase in outpatient caseload over previous years. Clearly, where public hospitals exist, they have demonstrated the commitment and capacity to provide needed outpatient services for unemployed persons.

o MOST PUBLIC HOSPITALS IN METROPOLITAN AREAS ALSO PROVIDE SPECIALIZED INPATIENT, PUBLIC HEALTH AND OTHER UNIQUE SERVICES. These services are often too costly or too "unreimbursable" for most private hospitals to maintain. They include burn units -- trauma centers -- emergency alcoholism, drug abuse, and child abuse centers -- neonatal intensive care -- poison control units -- to name just a few.

For this reason, we want to make clear that the full capacity also exists and is currently available to serve uninsured, unemployed citizens on the inpatient side as well as to provide needed ambulatory care.

Current Efforts to Assist the Unemployed

We believe it is extremely admirable that representatives of the private health sector -- physicians, private hospitals and other providers -- have come forward in recent weeks with plans to provide services free or at a reduced rate to the unemployed. We believe these efforts at augmenting the Federal, State and local governmental responsibility are essential, to preserve both the humanity and the fiscal integrity of our entire health system. David Stockman is simply wrong, however, if he thinks the private sector can succeed through voluntarism alone in meeting the tremendous health care needs of our nation's uninsured or under-insured population in a time of economic

crisis. Indeed, after surveying a number of our member hospitals in high unemployment areas this week, at the suggestion of Committee staff, we seriously question the extent to which admirable recent rhetoric about organized private sector assistance has yet been translated into reality in most parts of the country.

Our informal survey this week has thus far turned up the following reports of organized activities (or lack thereof):

Flint, Michigan (22%) [Hurley Medical Center]*

The Mott Foundation, in conjunction with the UAW, has developed a very small but innovative program to compensate physicians, hospitals and dentists for services to individuals who have lost their health benefits. A UAW sponsored program, operated through a community coordinating council, screens these individuals and refers those in need of care to one of three area hospitals and a number of physicians and dentists who have agreed to participate in the project. Since the amount of the original Mott contribution was so small ($20,000), the services supported have been mostly ambulatory. The program has been in existence for about a year, and a Mott spinoff -- the Flint Area Health Foundation -- has agreed to contribute additional funding.

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*In each of these reports, the name of the city is followed in parenthesis by its local rate of unemployment, as reported in mid-February, and the name of the public hospital providing the information.

Cleveland, Ohio (12.4%) [Cuyahoga County Hospital]

The Academy of Medicine in Cleveland has sponsored an initiative to organize volunteer physicians who would agree to care for unemployed individuals at a reduced rate or at no cost. The program was begun only recently, and utilization data is not yet available.

Indianapolis, Indiana (9.8%) [Wishard Memorial Hospital]

The Business Coalition of Indianapolis is beginning to address this issue, and is the only local body known to be doing so in an organized fashion. If anything, there has been a stronger attempt on the part of private hospitals to transfer their nonpaying patients to the public hospitals.

Chicago, Illinois (10.9%) [Cook County Hospital]

Cook County has seen no program at the State, local or municipal level to address the unemployment health issue, a problem substantially exacerbated by new Medicaid reductions proposed by the State.

Milwaukee, Wisconsin (12.2%) [Milwaukee County Medical Complex]

Milwaukee has only seen discussion of the issue, with no organized effort established to date.

Buffalo, New York (13.0%) [Erie County Hospital]

No organized programs.

St. Louis, Missouri (10.4%) [St. Louis City Hospital]

There are no organized projects underway. Rather, the Mayor proposed recently to close St. Louis City Hospital under increased pressures due to the recession -- including reduced local tax revenues. This past weekend, however, the Mayor announced -- following considerable pressure from private providers as well as representatives of indigent patients -- to try instead to pursue a $40 million program to construct a new hospital.

St. Louis, Missouri (8.8%) [St. Louis County Hospital]

No organized effort, but a substantial increase in the number of indigent patients:

	Unemployment	"Self Pay" Patients (Uncollected)	Other Indigent Patients
1982	7.8%	$5.6 million	$1.98 million
1983	8.8%	$7.3 million*	$3.2 million*

*based on $20 million total operating budget.

Fresno, California (15.3%) [Fresno County Valley Medical Center]

No organized efforts.

San Jose, California (8.6%) [Santa Clara County Valley Medical Center]

No organized efforts. Medical Society has considered the problem, but decided against action for now.

Ventura, California (12.5%) [Ventura County Medical Center]

No organized efforts. Instead, there has been an increased shifting of indigent patients in recent months due in part to the recent action of the State to reduce Medicaid for certain categories of low income adults.

Bakersfield, California (14.9%) [Kern County Medical Center]

No organized efforts. One hospital provides patients with a map to Kern County Medical Center.

Worcester, Massachusetts (8.3%) [Worcester City Hospital]

Recently announced effort by local Medical Society, but coupled with insistance that public hospital increase its services.

To be sure, our survey has been limited to metropolitan areas where public hospitals exist. In such areas, the pressure is clearly lessened for either rhetoric or action among private physicians or hospitals. Programs cited this week in the press, or in testimony before your Committee, that appear to be more successful are in those areas (Pennsylvania, Portland, Northern Virginia) where no public hospitals exist. Still, I was perhaps unprepared for the responses of several of our member hospitals as I telephoned them around the country this week -- not at the lack of private sector involvement, but at the additional bitterness and hostility they seem to be encountering. In many instances, public hospitals have received phone calls or letters from private physicians or hospitals demanding

assurances that all transferred patients would be served. In others, private emergency rooms have been closed and signs posted demanding large deposits from the uninsured poor. For every local story of the private physician who compassionately continues to serve his newly uninsured and financially strapped patient, there are other stories of the door slamming shut. Moreover, this has spilled over in many areas to an increased refusal to serve Medicaid and less-affluent Medicare patients as well.

In Bakersfield, California (unemployment rate: 14.9%) one private hospital has gone so far as to print maps and instructions for uninsured patients directing them to the County hospital. I will provide a copy of this map, and of other correspondence, for the hearing record.

In response to this disturbing trend, I would like to take this opportunity to make one point extremely clear to our unemployed, uninsured citizens (and indirectly, I suppose, to private hospitals, physicians, and the members of this Committee):

No matter what funding decisions are made in the Congress, or by the States, regarding additional support for health services, where public hospitals continue to exist, they will use every resource available to them to keep their doors open to you. Some of you may be unfamiliar with -- or perhaps suspicious of -- the quality of health care rendered at public hospitals in our nation's metropolitan areas. Please don't mistake the occasional lackluster shabbiness of the facades or the shortcomings in the

hotel-type amenities with a lack of quality or dedication on the part of our physicians and other professional staff. Let me suggest one fact which may help reassure you: In virtually every major American city, it is the public hospital which has been designated the President's hospital when he is traveling in that area. So please do not deny yourselves needed care simply because you have lost your insurance. To you -- and to the rest of the health care industry -- we want to make clear that we will uphold our commitment.

Comments on Proposed Legislation

In this time of economic crisis we do need and appreciate the assistance of private health care providers. We also greatly appreciate any additional support the federal government might be able to provide, and we urge you to enact legislation as quickly as possible to provide that support. As we have indicated in previous testimony, we generally consider the fact of that support to be more important to our hospitals and our patients than the precise way you may choose to provide it. As the New Yorker's Calvin Trillin once said, "New York City loves counter-cyclical revenue sharing -- or whatever else the government is calling money this year".

However, based on our members' longstanding role as principal providers of care to all uninsured persons, we do have a number of comments to make on the legislation before you today. The two principal bills on which I will comment are

S. 307, introduced by Senator Riegle, and S. 951, introduced by Senator Dole for himself and several other members of this Committee.

As between the two bills currently before this Committee, NAPH would prefer the approach to solving our pressing anti-recessionary health problem in S. 951.

Comments on S. 307

S. 307 has two major components: a long term plan to require the creation of State reinsurance pools to cover unemployed workers for up to 18 months following job loss, and an emergency plan to enroll current unemployed and uninsured persons and/or their families in the Medicare program.

With regard to the long range plan, NAPH members believe any long range efforts to address the health insurance needs of uninsured individuals must take into consideration all persons who currently fall through the cracks in America today. It is simply unacceptable to target only the needs of a narrow range of uninsured persons in any long range reform.

With regard to the emergency portion of S. 307, we agree that it is appropriate to target this narrower group in the short run. However, we consider the Medicare program an entirely inappropriate mechanism for this purpose. The Medicare benefit package is likely to be inappropriate to the needs of many of the unemployed and their families -- both too broad (in covering a wide range of elective procedures) and too narrow (e.g., failing to cover necessary drugs) to serve the genuine emergency

health needs of this population. Many unemployed persons will be unable or unwilling to pay the 20% premium and all the various Medicare deductibles, coinsurance, and extra payments to physicians who refuse to accept assignment. Nor is there any effort to target this assistance on areas of high unemployment. Any federal assistance for emergency health care must be much more carefully targeted than the current Medicare program.

Comments on S. 951

S. 951, on the other hand, establishes a new section to title XX of the Social Security Act, to provide grants to States which establish programs for providing health care coverage for unemployed workers. To summarize this proposal:

States may choose groups to be covered, except that they may not cover persons who are not or have not in the past 6 months been eligible for unemployment insurance benefits and were not enrolled in a group health plan. Qualifying individuals become eligible six weeks after unemployment for a package of services limited to inpatient services, emergency outpatient hospital physician and clinic (but not SNF) services, and prenatal and postpartum services. No drugs or biologicals may be provided except for inpatients, and the State may set the amount, duration and scope of services, provided they are no more generous than under the State Medicaid program. States may charge premiums of up to 8% of an individual's unemployment insurance benefit, and may provide for deductibles after public hearings of up to 10% of that amount (except for prenatal and postpartum care). Individuals may decline enrollment, but may

not then be eligible again for the balance of their unemployment insurance "benefit year". The program is to be administered through the State's Medicaid agency, except that eligibility determinations are to be made by the State Employment Service. $750 million is allotted to the States for this program, to be divided among them half on the basis of the relative number of uninsured unemployed and half on the basis of the relative number of longterm unemployed. States must establish a program to receive funding -- funds allotted to any state which does not will be reallocated among all other States. The federal share of program costs will be 95% if the State's uninsured unemployment rate exceeds 5% and 80% if it is less. (Insured unemployment generally runs two percentage points below the rate of overall unemployment -- it is the latter rate which is most generally reported). An additional $150 million is allocated for administrative costs ($70 million for State Medicaid agencies and $80 million for the Labor Department).

The program applies to services rendered after June 1, 1983. No State may receive federal funds for new enrollees after October, however, if its rate of insured unemployment falls below 4%. Finally, the deductibility of employer health plans will be reduced by 50% if they do not permit open enrollment of the newly unemployed spouse or parent of an enrolled individual.

In general, NAPH strongly supports the general thrust of this approach, and many elements of it are consistent with proposals we put forward initially last summer in our Public

Hospital Legislative and Policy Agenda (see Section IIE of that agenda, attached at the end of this testimony). The funding level ($750 million per year), while not extravagant, would clearly have an impact on the needs of this population (and the providers which serve them). We support the relatively narrow targeting of this assistance on needed emergency, inpatient and maternal and child care, and further agree that it is appropriate to limit the amount, duration and scope of services to those of a State's Medicaid program. We have even supported the concept of a premium and/or copayment for unemployed individuals, if such limitations are sensitively and equitably administered. Against that background of strong conceptual suppport for this approach, we would thus like to offer several comments and recommendations for improvement in this bill. Those concerns and recommendations fall generally into four categories:

1. Concern with the administration of this program by (and its limitation only to) States;

2. Concern that the program would limit States only to establishing a new entitlement program rather than exploring other, possibly more cost-effective, ways to provide care;

3. Concern that the "benefit package" be clearly defined to meet the genuine short term needs of the unemployed; and

4. Concern regarding the methods and criteria to be used to determine the eligibility of unemployed and uninsured persons under this new program.

In the remainder of my testimony, I will summarize our concerns and recommendations in each of these four areas.

1. Administration of the Program Through States

Our general concerns with this aspect of the proposed legislation are two-fold: first, that even the modest cost sharing requirements or other considerations may cause some States to choose not to establish a program, thus inequitably penalizing the unemployed residents of such States, and second, that even if a State does establish a program, there may be insufficient controls in the bill to guarantee its most equitable and efficient administration. We recommend the following modifications in S. 951 to address these concerns:

a. The bill should be amended to permit units of local government, or combinations of such units, with high levels of unemployment within States to apply independently for funding in any State which refuses to establish a program.

b. Larger SMSAs determined to be particularly harshly impacted by unemployment and the recession should be permitted to establish separate programs even if the State also chooses to apply.

c. A strict maintenance of effort provision should be adopted to prevent States from simply using this program as a windfall to replace funds currently spent on other health care activities and programs.

d. While permitting States explicitly to limit eligible providers is appropriate, an amendment should be adopted consistent with the provisions adopted by this Committee in the Medicaid and Medicare laws requiring special consideration of the needs of public hospitals and other providers already serving substantial numbers of uninsured patients.

2. Creation of New Entitlement

While giving States appropriate flexibility in a number of ways to establish programs suitable to unique local needs, we are concerned that programs will be limited by this bill only to those which establish new individual entitlements. While perhaps suitable in some areas and for some populations, new entitlements in the current era of budget uncertainty may prove to be an extremely inefficient way to guarantee the availability of needed health sevices for the widest number of unemployed persons. Entitlements in a short term emergency program such as this run counter to the trend in many areas away from unit-charge or fee-for-service care for the poor, and may encourage overutilization instead of efficiency. At the very least, we would recommend that the following modifications and flexibility be adopted in this area:

a. States (or other grantees under this program) should be permitted to establish a non-entitlement program which would allot funds to individual providers or provider groups to guarantee that the requisite benefits would be made available to any and all eligible individuals in need of such services. (This approach might also avoid the need for a costly enrollment process. Eligible individuals would simply be informed of the availability of services and the designated providers would be required to make a reasonable accounting of services provided to such individuals).

b. For areas of particularly high unemployment, a direct grant program should be provided for institutional support of public hospitals (and other providers) which maintain "open door" policies and provide health care services to unemployed persons and all other uninsured individuals.

3. Definition of Benefit Package

Our principal concern in this area is that the benefits available under this program, while appropriately narrow, not be defined in such a way as to encourage patients to postpone needed services until the problems are severe or discourage them from seeking necessary health care in the most cost-efficient setting. In this regard, the following recommendations are made:

a. "Emergency" outpatient services for which payment may be available should not be unduly limited (e.g., to life-threatening conditions), but rather, should be

clearly defined to include conditions which, in the opinion of the patient's physician, would lead to more severe health problems if treatment were not rendered; and

b. Flexibility should be granted to pay for certain types of drugs or biologicals (such as for asthmatic children or necessary chemotherapy for cancer patients) on an outpatient basis, in order to avoid unnecessary (and expensive) hospitalization to acquire such drugs or more severe health problems resulting from the inability of patients to afford them.

4. Determining Eligibility for Services

Finally, in this area, our concerns are with both the scope and the method of determining eligibility. With regard to the former, limiting coverage under this program only to workers who have collected or exhausted unemployment insurance benefits and who were previously enrolled in group health plans seems unnecessarily restrictive and may in some cases prove inequitable. Also, permitting eligibility to be granted to an individual only for a limited time period may also inequitably discriminate against some unemployed persons. With regard to methodology, it is likely to be quite inefficient and burdensome to require eligibility to be determined only through the State Employment Service -- which has little or no experience administering health benefit programs and is rarely located

conveniently for health care providers who often must take it upon themselves to determine eligibility for an emergency patient.

For these reasons, we recommend the following modifications to the bill:

a. States (or other grantees) should be permitted to include coverage at the very least of insured unemployed individuals regardless of whether such individuals were previously enrolled in a group health plan.

b. States (or other grantees) should also be permitted to let eligibility be determined at any time the program is in effect in the State, at least for those unemployed individuals who have not explicitly rejected enrollment in the program.

c. States (or other grantees) should also be permitted flexibility to allow eligibility to be determined by State, local and hospital employees currently permitted to determine eligibility under Medicare and other indigent case programs.

I and the member hospitals of NAPH would be pleased to work with the Committee on these recommendations, as well as any others which may be necessary to permit this program to respond equitably and efficiently to the serious health care need your bill has so commendably addressed.

Thank you once again for this opportunity to testify. I would be happy at this time to answer any questions you may have.

Excerpt from "NAPH Legislative and Policy Agenda," June 23, 1982

E. Emergency Health Care for the Unemployed

Another health crisis which we believe deserves greater attention from the federal government in a time of severe economic disruption involves the very real and significant health care needs of unemployed workers who have lost their insurance coverage. This is a problem which has been a subject of attention for Congressional policymakers in the past. But earlier pressure for passage of legislation was alleviated by a combination of factors, including the fact that workers in some industries (such as the auto industry) were able to negotiate contracts including extended health coverage during periods of unemployment.

Many unemployed workers today enjoy no such protection, however, and with unemployment in some parts of the country approaching Depression-era levels, the health care needs of many such workers will be considerable. For a variety of reasons, unemployed workers are unlikely to become eligible for Medicaid in many states. Thus, the burden of providing health care for such individuals and their families will inevitably fall on the cities and counties, and their public health and hospital systems. We believe this will be true despite the admirable efforts of private hospitals in some parts of the country (such as with Detroit's "Project Health Care") because private payers are unlikely to be able in the long run to continue to absorb the bad debt/charity care load of the unemployed.

For this reason, we are proposing that Congress adopt at least a limited, targeted assistance program for the coming fiscal year which would provide additonal support to state and local governments, or coalitions of private and public providers, to help contend with this problem.

We have not drafted a specific legislative amendment to accomplish this goal. Rather we suggest that such a program, in order to be most effective within limited budget constraints, might have the following general characteristics:

- It would trigger "on" and "off" nationally whenever the nationwide unemployment rate is above or below a selected percentage for three consecutive months;

- It would provide funds directly to a state with an unemployment rate at or in excess of the national average or to a local government in a similarly-impacted SMSA. If neither the state nor the local government chooses to participate in the program in such an area, a coalition of community hospitals and other providers could be made eligible to receive federal funds;

- It would provide 50% of the cost of funding either a temporary catastrophic health insurance benefit for individual eligible unemployed workers and their families, or providing institutional support to guarantee the availabililty of specific hospital and primary care services to such individuals;

- "Eligible unemployed" would include those with demonstrated workforce attachment, without any residual health insurance (either directly or through another member of the family);

- Eligibility would terminate with a new job, with a decline in national or area unemployment (with a provision for orderly transition) or after a specific period of eligibility for each worker;

- As a further safeguard, there could be a clear sunset for the program regardless of level of unemployment, to permit Congress to measure its effectiveness, and an annual cap on federal expenditures; and

- Beneficiary copayments or cost sharing could be made an optional or mandatory feature.

The CHAIRMAN. Thank you very much, Mr. Gage.

I might say to some of those standing—there are about a dozen seats up here; unless you prefer to stand, I'd be happy to have you move up. It's not very comfortable standing.

Senator Durenberger.

Senator DURENBERGER. Well, I appreciate very much the testimony of both of the witnesses, and particularly their full statements.

Mr. Chairman, we did ask both of these organizations to do a little extra work beyond the prepared testimony, and that is included in their full statements. I think we appreciate that a great deal.

I made a little speech up in New York to the American Society of Public Administration over the weekend, where I sort of took a look at the gas tax bill which was designed to create jobs, and then I took a look at the emergency jobs program, which was designed to create jobs. And then I talked a little bit about all these infrastructure proposals around here and showed how we were doing such a great job of taking over pothole filling and streetbuilding and post office construction, and God knows what else around this country, at the same time we are talking about devolving responsibilities to local governments, that you really have to wonder whether we've got our heads screwed on straight.

And I went on to make the statement that the best infrastructure program we could start in this country would be to federalize medicaid.

Every time I say that I have to hasten to explain it, in terms of the fact that one of the things that probably we can do best in combination with the private sector and local government is to finance income security in this country, or at least to undergird the access of people to social services, and to health care, and to all those sorts of things.

Where we do a lousy job is when we start deciding which potholes get filled and which bridges get built, and all the rest of that sort of thing.

I think we are running a risk right now, at this particular point in time, of wasting billions, and billions, and billions of federally collected tax dollars on things we don't know anything about here in this Congress, when a small part of that money built into the health care system, as delivered always at the local level like in the private sector, through some appropriate combination of means that we are all very familiar with, would go a lot further toward helping the people of this country.

I want to thank you. We are certainly indebted to both of you and to all of your members who are starting to move this health policy in this country in the right direction.

The CHAIRMAN. Thank you, Senator Durenberger.

I have no questions. Again, we appreciate your working with the committee. This is the first stage of what we hope to put together rather quickly, awaiting some indication from the administration. I think you have expressed your willingness to work with the staff and work with others of us, primarily Senator Durenberger who will have to carry the heaviest load.

So we thank you very much.

Mr. OWEN. Thank you, Mr. Chairman.

Mr. GAGE. Thank you.

The CHAIRMAN. Our next witness is Tom Samek.

Tom, do you want to come up? I understand you just had your first plane ride this morning. That was one experience; this may be another first. We don't go up quite as high here, but——

[Laughter.]

The CHAIRMAN. I know Senator Heinz wants to be here. Right now he is voting on something in the Energy Committee and will be down as quickly as he can.

We will be very happy to hear your testimony. You may proceed in any manner you wish.

STATEMENT OF THOMAS SAMEK, FORMER MINEWORKER, JONES & LAUGHLIN, GREEN COUNTY, PA.

Mr. SAMEK. My name is Tom Samek. I am from Crucible, Pa. I am an unemployed coal miner and a member of the United Mine Workers.

On March 2, 1982, I was laid off along with 300 other members. Our wage agreement calls for a prorated basis for your health insurance. I was there 5 years; I had enough time to have 1 year's coverage paid by the company.

On March 31 of this year my insurance ran out. We had members of our local union that were younger than me that only had 28 days coverage, and we had members that had 6 months coverage. I was lucky, I had 1 year's coverage.

My wife was due to have a baby on March 11 of this year. Well, as things went on the doctor said maybe it would be into April, so I called Blue Cross and Blue Shield of western Pennsylvania. I told them about my problem, and they said that they had to offer me a conversion plan. It would be $192 a month.

Now, my unemployment benefits are $198 a week. They expired 3 weeks ago, but on April 19 I was informed that I would get a 10-week Federal extension. I thought there is no way I'm going to be able to afford this insurance, but I have to have it because my wife's going to have a baby.

So on April 11 she went into labor. She had an emergency C-section. She was in the hospital for 5 days, and my hospital and doctor bills came to $5,927.43.

I didn't have the money to pay for my insurance, so my uncle gave me $180 yesterday to pay it. It's due by midnight tonight, or I'd have no coverage at all.

When the woman from Blue Cross told me that I could pay $192 a month I thought, well, in the month of April I'm going to have to have this money; I'll save it. Well, I haven't gotten an unemployment check for 3½ weeks, so I didn't have the money.

Well, the day before my wife went into the hospital, which was a Saturday, I got a bill from Blue Cross in the mail for $578—and I think it was 76 cents. I didn't have time to call them; it was a Saturday. My wife went into the hospital Monday morning. I didn't call them for the whole week she was in the hospital.

I got hold of them the other day. They told me I had to pay quarterly, which was $578, or I couldn't have the insurance.

Well, when I got out my old phone bills, and I explained to the woman that they did tell me I could pay monthly, which was $192; we talked for about 15 minutes, she promised me that I could pay bimonthly, which would be $394 and some cents.

I told her I didn't have that kind of money. We talked a little bit longer, and she did agree that they would take it on a monthly basis.

I got the money from my uncle. My insurance is paid for this month. Come May 1, there is no way I can afford this insurance. There are 300 other people that I know of from where I work that can't afford this insurance, and if something could happen, God only knows what the bills could run into. My wife and baby were in the hospital for 5 days and I have a bill here of darn near $6,000.

My unemployment benefits are running out in 10 weeks; I can't keep up this insurance. Like I said, if something happens again I have no idea what we could do.

I appreciate your concern, and I'm thankful that you let me come here to speak.

[Mr. Samek's prepared statement follows:]

I am Thomas Samek from Crucible, Pennsylvania. I want to thank Senator Heinz for inviting me here to speak today. I would also like to thank the UMWA for paying my expenses. My reason for being here is to tell you how unemployment and lack of health insurance has affected my life in the past couple of months.

I was formerly employed as a belt mechanic at Jones and Laughlin's Vest #5 mine. I normally worked 7 days per week, a normal day was 11 hours long. When I got this job I had dreams of building a new home for my wife and family. My dreams now are to find a job. I was laid off on March 2, 1982. My unemployment benefits expired on March 26, 1983. Tuesday, April 19, I was notified that I will receive a 10 week federal extension on unemployment benefits.

It is important to me to be able to support my wife and three children as I have been looking for work since I was laid off. Our third child was born on April 11, 1983 and my health insurance wouldn't have covered these expenses had my uncle not given me $179.41 for a one month payment. My insurance with Blue Cross had expired on March 31, 1983 but the payment I made yesterday will cover my family only until May 1, 1983. I will not be able to pay these premiums any longer. If any member of my family needs medical attention after May 1, I will have to pay the bills myself, which is impossible since I am unemployed. I could apply for a Medical Assistance Card or apply through Greene County Memorial Hospital for Hill-Burton assistance. Neither of these choices would pay doctor bills and I would rather not apply as I feel it is my responsibility to pay these bills.

Two months before Jeff was born I contacted Blue Cross-Blue Shield. I was told after Jones and Laughlin cancelled my covered I would be offered a

conversion plan. The woman told me the plan would cost $192 a month, payable monthly beginning in May. She told me there would be no lapse in coverage and I could buy all or any portion of the plan.

On Saturday, April 9, I got a bill from Blue Cross for $578.75 that was to be paid by April 21, 1983. On Monday, the 11th, my wife was in labor and her doctor admitted her to the hospital for an emergency C-section. There were complications and she was in surgery for 4½ hours. My wife and son are fine now. My wife and son even came home a day early, just in case Blue Cross wouldn't accept one month's payment. After quite a long discussion with Blue Cross they agreed to accept the one month's payment.

I have not received an unemployment check in 3½ weeks. If I had not paid the premium, I would be facing:

$4,154.67	hospital bill for my wife
642.76	hospital bill for my son
935.00	doctor bill for my wife
195.00	doctor bill for my son
$5927.43	Total

Both the doctor and Greene County Memorial Hospital's billing office have been very understanding about our problems and were willing to work with us to find a way to pay our bills.

I just want to tell you that being unemployed and not having health insurance is a hard way to live. It hurts not being a good provider for my family and it hurts deeply to be dependent on others.

20 April 1983

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Tom, I want to ask you about the proposal here. This is just your personal experience, and obviously you won't be speaking for 6 million folks that might be in your same position, but I can understand what you were going through in trying to make this conversion decision.

We have a proposal here which says that you can buy insurance—probably not quite the same full set of benefits but it would provide hospitalization and doctor, and the kind of help with pregnancy and delivery, and that sort of thing.

The proposal would say that, in your case, the State of Pennsylvania would set up a program where when you found yourself on March 2, or whatever it is, going off of the union coverage that you had—you get about $198 a week, I think you said, in an unemployment compensation check?

Mr. SAMEK. Yes, $198.

Senator DURENBERGER. Well, they could set up a program that at the maximum would ask you to pay about $15.80 a week out of that check to buy an insurance plan. And that insurance plan couldn't ask you to pay on top of that when your wife did have a baby; it couldn't ask you to pay any more than about another $4 or the equivalent of $4 a week. So you wouldn't be getting any of those $500 bills.

Do you just personally have any problem, in order to get the coverage, of taking a little amount like $15.80 out of a comp check each week to buy that kind of coverage? Or do you think that somehow we should be doing this for nothing here?

Mr. SAMEK. If I was going to get unemployment for a long period of time, that would be fine. But, as I said before, my benefits have completely expired. I went 3 weeks without having any benefits, and I just signed up the day before yesterday for a new 10-week extension.

That would be wonderful to pay $60 a month or $15 a week for insurance; but when my benefits run out in 10 weeks, I don't know where I would get the $15, let alone feed my family and pay my bills.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Mr. Samek, we appreciate very much your testimony. I think it indicates there are some people who think there isn't any problem because they don't have the problem. But you have the problem, and I think your mere presence here and your statement should indicate to this committee, and those in Congress, and the administration, and elsewhere, that there are real people out there who would like to go back to work. I assume you would rather go back to work than to be here today?

Mr. SAMEK. Very much. I would gladly go to work.

The CHAIRMAN. But there isn't any work.

Mr. SAMEK. I have been looking for work since March 1982. When I first got laid off I went around to other mines and stuff and applied for jobs, and it seemed like it was just like dominoes. Our mine laid off first, 300 members, and they just started failing and shutting down, and I think the unemployment rate in Green County is 18 percent.

I go and look for a job—you search. Half the people don't want to leave you in the door; the other people, you ask them, Are you hiring? They laugh. I mean, it's a shame. There is nowhere to find a job.

The CHAIRMAN. Are the prospects any better now than they were six months ago or month ago?

Mr. SAMEK. Well, for the mine in which I worked, and I'm on a panel for them to be called back, there were 300 men laid off in March 1982. It's been 13 months; they've called 10 men back. There must have been 30 men that retired. The jobs aren't even being filled, but the men are leaving. It certainly doesn't look like it's going to get any better for now.

The CHAIRMAN. Well, I have no specific questions. I think your testimony will certainly be helpful as we look at and try to address the real problem.

I think there is broad support for doing something. As Senator Durenberger pointed out, under our proposal, instead of being that massive amount that you don't have, it would be a smaller amount that you don't have. I guess that's the problem, right? Instead of $180 you don't have, this would be $60 that you don't have, so it's still a big problem. I'm not certain how we address that, but it's another factor we'll have to consider.

I wonder if you might be willing to just wait a few minutes? I don't know what your schedule is, but I know Senator Heinz wants to be here. Could you just wait a few minutes? Is that all right?

Mr. SAMEK. Yes. I'm not supposed to fly home until later on this afternoon, so I can wait.

The CHAIRMAN. OK; I think he will be here, and we might want to call you back briefly.

Mr. SAMEK. OK; thank you very much, and I appreciate your concern.

The CHAIRMAN. Thank you.

Our next witness is Mr. Ray Denison, director of the department of legislation, AFL-CIO.

Ray, again I will say as I have said to the other witnesses, we will insert your entire stitement in the record. We hope that you might be able to summarize it for us.

Mr. DENISON. I will be happy to summarize it, Mr. Chairman.

STATEMENT OF RAY DENISON, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS, WASHINGTON, D.C.

Mr. DENISON. I am accompanied this morning by Karen Ignagni, assistant director of our social security department.

The AFL-CIO appreciates the opportunity to present our views on the bills before this committee which address the urgent need of health care for the unemployed.

We commend you, Mr. Chairman, for your leadership in addressing one of the most serious and lasting consequences of unemployment by introducing S. 951.

Joblessness today is often no longer a short, temporary setback for workers but is resulting in longer periods of joblessness, greater

exhaustion of financial reserves, and, frequently, permanent economic, social, emotional, and physical health problems.

In every other industrial country except South Africa health care is a right. All citizens are entitled to services. In this country, access to health care services is contingent upon where you work or how much you can pay.

Organized labor is evaluating all legislative proposals to provide health care to the unemployed on the basis of eight principles:

First, the program must not concentrate exclusively on catastrophic care. If the program is to be cost effective and meet the health care needs of the unemployed, preventive care and diagnostic services must be offered. Prenatal and postpartum care are especially important.

Second, the program must use cost-effective reimbursement mechanisms, such as negotiating per-capita agreements with providers.

Third, workers who have exhausted unemployment compensation must be eligible for services.

Fourth, public employees must be eligible for the benefits for which other employees are eligible.

Fifth, cost sharing on the part of the unemployed beneficiaries should be limited to nominal amounts required under medicaid.

Sixth, providers who participate in the program must accept assignment.

Seventh, a grant program should be created for public hospitals.

Eighth, funding for the programs must be adequately based on levels of unemployment.

S. 951 attempts to share scarce resources equitably umong the unemployed, the States, and the Federal Government, and although we support this basic approach to the problem we have reservations about eligibility, cost-sharing State match, and the authorization level.

We fully support the view that health care for the unemployed be administered through State medicaid programs. This puts the States at risk and provides strong incentives for them to negotiate cost-effective reimbursement contracts directly with providers.

We are pleased that the bill provides a benefit package, which includes prenatal and postpartum care, but would urge the inclusions of visits to a doctor's office as part of the benefit package, since data indicates that the severe health care problems which affect jobless workers could be dramatically reduced by improving their access to preventive health care services.

The AFL-CIO urges an increase in the authorization in S. 951 to a level that adequately addresses the health care needs of unemployed workers. This would allow States to reach further back and provide access to those who have exhausted compensation within the last 2 years, reduce the amount that jobless workers would be required to pay out of pocket for services, and allow 100 percent Federal funding to States with very high levels of unemployment.

We would also urge allocating money to States based on their total unemployment rates.

The AFL-CIO recommends that the chairman consider using in his bill an allocation formula like the one in S. 811, by Senators Specter and Heinz. The formula in that bill allocates one-third of

the amount to States, on the basis of the relative number of unemployed who reside in each State; one-third on the basis of the relative number of unemployed individuals in excess of 6 percent of the civilian labor force in each State; and one-third on the basis of the relative number of individuals who have been unemployed for 15 weeks or more and who reside in each State.

We would also like to commend Senators Riegle, Levin, and Metzenbaum for acting swiftly on this problem by introducing S. 307. We do have reservations, however, about administering a national program of health care through State insurance pools. We are also concerned about the high deductibles that could be imposed on jobless workers and the lack of coverage.

Finally, I would like to give our views on proposals to finance health care for the unemployed by placing a limit on the amount of tax-free employer contributions to health care. These are two totally different issues that should not be joined.

Congress must move swiftly to provide access to health care for the unemployed. There is widespread support for such a program; on the other hand, there is widespread opposition to placing an arbitrary limit on tax-free employer contributions for health insurance.

Today, the ravages of recession have cut deeply into the lives of millions who have never been jobless, who have never been without health care protection. The ideal solution to the problem is a revived economy, with jobs and the benefit protection that usually accompanies that employment.

In the meantime, we must minister to the victims, the wounded of our national economy's breakdown. As a major step to that end we urge you to act expeditiously on a program to provide health care for the jobless workers and their families.

[Mr. Denison's prepared statement follows:]

TESTIMONY OF RAY DENISON, DIRECTOR, DEPARTMENT OF LEGISLATION
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE SENATE FINANCE COMMITTEE
ON VARIOUS PROPOSALS TO PROVIDE HEALTH CARE FOR THE UNEMPLOYED

April 21, 1983

The AFL-CIO appreciates the opportunity to present our views on bills before this committee, which address the urgent need of health care for the unemployed. We commend you, Mr. Chairman, for your leadership in addressing one of the most serious and lasting consequences of unemployment by introducing S. 951, to provide health care coverage for the unemployed. Our testimony today will also address S. 307 and S. 811.

During the last two years, programs which have helped to sustain jobless workers have been greatly weakened. The support systems, which workers have relied on since the great depression, are no longer able to cushion the blow of unemployment. As a result, joblessness is often no longer a short, temporary setback for workers, but is resulting in longer periods of joblessness, greater exhaustion of financial reserves and, frequently, permanent economic, social, emotional and physical health problems.

Despite years of effort the United States has no national program to provide jobless workers access to health services to enable them to cope with the continuing medical needs, the high cost of care and the high level of stress associated with unemployment. In every other industrial country except South Africa, health care is a right. All citizens are entitled to services. In this country, access to health care services is contingent upon where you work, or how much you can pay.

Where health care coverage is terminated, the unemployed tend to postpone health care services until their conditions require emergency attention. When they do seek treatment, jobless workers use hospital emergency rooms and/or inner-city hospitals. The unemployed have very few financial resources. Most cannot afford to pay for health care. Nonpublic hospitals that do not turn jobless workers away, ultimately add the cost to patients covered by private health insurance. As for public hospitals, these facilities continue to be the providers of last resort for the elderly, the poor and those without health insurance protection. Public hospitals are experiencing a tremendous growth in the number of uninsured patients they treat at a time when their financial support from local governments has reached an all-time low. This new influx of patients could seriously jeopardize their ability to operate and continue to deliver services to the elderly and the economically disadvantaged who have always depended on them.

For these reasons, the AFL-CIO fully supports the creation of a countercyclical grant program for public hospitals and urge the members of this committee to consider incorporating such a provision into any Senate bill providing health care to the unemployed.

Before sharing with you our views on the proposals which have been introduced in the Senate to provide access to health care services for the unemployed, the AFL-CIO would like to state clearly our answer to those who assert that legislative solutions are unnecessary and that voluntary programs can adequately meet the health care needs of jobless workers. Although we acknowledge the importance of voluntary

programs and have been working with the American Medical Association, the American Society of Internal Medicine and other specialty societies, the AFL-CIO does not regard these efforts as adequate substitutes for a nationwide program to provide health care for the unemployed. As a society, much more needs to be done -- and done immediately, unless we are prepared to stand by and watch jobless workers suffer with neglected health care problems.

Organized labor will evaluate all legislative proposals to provide health care to the unemployed on the basis of the following eight principles:

1. The program must not concentrate exclusively on catastrophic care. If the program is to be cost-effective and meet the health care needs of the unemployed, preventive care and diagnostic services must be offered. Prenatal and postpartum care are especially important.

2. The program must use cost-effective reimbursement mechanisms, such as negotiating per capita agreements with providers.

3. Workers who have exhausted unemployment compensation must be eligible for services.

4. Public employees must be eligible for the benefits for which other employees are eligible.

5. Cost-sharing on the part of the unemployed beneficiaries should be limited to nominal amounts required under Medicaid.

6. Providers who participate in the program must accept assignment.

7. A grant program should created for public hospitals.

8. Funding for the programs must be adequately based on levels of unemployment.

S. 951 introduced by Chairman Dole along with Senators Durenberger, Heinz and Spector, attempts to share scarce resources equitably among the unemployed, states and the federal government. Although we support this basic approach to the problem, we have reservations about eligibility, cost-sharing state match and the authorization level. We fully support the view that health care for the unemployed be administered through state Medicaid programs. This puts the states at risk and provides strong incentives for them to negotiate cost-effective reimbursement contracts directly with providers. We are pleased that the bill provides a benefit package, which includes prenatal and postpartum care but would urge the inclusion of visits to a doctor's office as part of the benefit package, since data indicate that the severe health care problems which affect jobless workers could be drastically reduced by improving their access to preventive health care services.

The AFL-CIO urges an increase in the authorization in S. 951 to a level that adequately addresses the health care needs of unemployed workers. This would allow states to reach further back and provide access to those who have exhausted compensation within the last two years, reduce the amount that jobless workers would be required to pay out-of-pocket for services, and allow one hundred percent federal funding to states with very high levels of unemployment. We would also urge allocating money to states based on their <u>total</u> unemployment rates. As written, S. 951 allots one-half of program funds on the basis of insured unemployment rates and the other half of the funds on the basis of the number of individuals in each state who have been unemployed for 26 weeks or more. Insured unemployment rates accurately reflect the numbers of

jobless workers currently receiving compensation but do not reflect those who have exhausted coverage. Therefore, to make absolutely certain that states with the greatest need receive funds and, especially if eligibility is expanded to include more workers who have exhausted benefits, we recommend allocating all funds under this bill to states on the basis of their total unemployment rates.

S. 811 introduced by Senators Spector and Heinz, is a good first step towards providing financial incentives to states to become case managers and negotiate cost-effective reimbursement contracts directly with providers. If the committee considers this proposal, we recommend tightening it up to provide more guidance to states. Specifically, the bill should contain a minimum benefit package, which states can improve upon, but can offer no less. There should be limitations on premiums and out-of-pocket payments by unemployed workers for services, and Medicaid should be the intermediary in all states.

The AFL-CIO recommends that the Chairman consider using in his bill an allocation formula like the one in S. 811. The formula in the Spector, Heinz bill allocates one-third of the amount to states on the basis of the relative number of unemployed who reside in each state; one third on the basis of the relative number of unemployed individuals in excess of 6 percent of the civilian labor force in each state; and one-third on the basis of the relative number of individuals who have been unemployed for 15 weeks or more and who reside in each state.

The AFL-CIO would like to commend Senators Riegle, Levin and Metzenbaum for acting swiftly on this problem by introducing S. 307 early in this Congress. We do have reservations, however, about administering a national program of health care for the unemployed through state insurance pools. We also are concerned about the high deductibles that could be imposed on jobless workers and the lack of coverage for primary care.

We would like more time to study the effect in S. 307 of requiring employers to continue health insurance coverage for laid off workers.

S. 307 would require unemployed workers to pay a premium of 20 percent and deductible of $500. The AFL-CIO believes that the federal government should set a cap on premiums and the states should have public hearings to decide whether premiums are to be imposed and, if so, how much. In addition, if jobless workers are required to make out-of-pocket payments for services, they should be limited to the nominal amounts now authorized under Medicaid.

Finally, since state and local governments can decide on their own whether to contribute to state insurance pools, it is not at all clear in S. 307 how their employees would receive health care services if they were laid off.

Before concluding our statement, Mr. Chairman, I would like to give you our views on proposals to finance health care for the unemployed by placing a limit on the amount of tax free employer contributions to health care. These are two totally different issues that should not be joined. Nor can we try to rob Peter to pay Paul. Congress must move quickly to provide access to

health care for the unemployed. There is widespread support for such a program. On the other hand, there is widespread opposition to placing an arbitrary limit on tax free employer contributions for health insurance. We strongly urge that Congress not seek to prevent passage of a health care program for the unemployed by holding it hostage to extracting a pound of tax from health care employer payments.

Today, the ravages of recession have cut deeply into the lives of millions who have never been jobless, who have never been without health care protection. The ideal solution to this problem is a revived economy with jobs and the benefit protection that usually accompanies that job. In the meantime, we must minister to the victims, the wounded of our national economy's breakdown. As a major step to that end, we urge you to act expeditiously on a program to provide health care for jobless workers and their families.

The CHAIRMAN. Ray, thank you very much.

Senator Durenberger.

Senator DURENBERGER. Ray, I don't want to ask a question about the last part, but you know the two of us care about it. I don't want to argue whether there is a connection or not, but one of our problems in all of this as we approach the ideal solution is the high cost of employing people in America.

We sure were sensitive to that when we did the social security reform, and we've got a variety of proposals—one down the street that says we ought to finance continuity, or at least this was talked about down the street, finance continuity of coverage out of increased payroll taxes, and so forth.

I am sure you share the employers concerns in this country for the high cost of employing people. And obviously, just in terms of a sense of direction, I don't come to my support of the so-called tax cap from the standpoint of raising revenue; I come to it from the standpoint of what's the appropriate cost of employing people, and can't we find a better way to do it?

Also, I don't know whether it is in your prepared statement, but I know in my State, and I assume in other States, the AFL-CIO has taken a lead in putting together responses to the health care problems of people in this country, and it's the AFL-CIO, because it is sensitive to the problems that people like Tom are having, in a lot of communities are putting people together with doctors and hospitals, and so forth.

If you could, either just confirm that for the record or give some indication of the role that unions across the country are playing in helping fill this gap. It might be helpful to all of us, also.

We've heard what the docs are doing, and the hospitals, and so forth, but maybe you have some observations on it.

Mr. DENISON. Well, we have certainly been working with the medical establishment, the health care establishment, wherever we can. We have a permanent department in the AFL-CIO, community services, working in the State organizations, and certainly our own Social Security Department has been working with all health delivery organizations wherever we can for the purpose of bringing down the cost of health care. We have certainly been deeply involved in all health care containment proposals.

Getting back to the matter of a cap, it is our concern in that area, inasmuch as it is our belief that the health care provisions that are negotiated through collective bargaining agreements are, in effect, an allocation of funds received at the collective bargaining table. The choice was not to take them in wages, not to take them in pensions, but to take them in the form of health care coverage, and as comprehensive as possible. And union programs generally are far more comprehensive and far more complete, thus taking away the need for the Government and the community to provide any incremental health care.

So this would mean, in effect, a taking-away in an arbitrary manner of what is a collectively-bargained decision by both management and labor. We would be concerned about that in this area, just as we are concerned about rumblings we are hearing about similar concerns or similar attitudes in the pension area.

So we are very sensitive to that area, because it represents the fruit of tens of thousands of collectively bargained contracts.

Senator DURENBERGER. Leaving the collective bargaining part of it out and trying to maybe read something into your statement, there are various ways we can go about Tom's problem while he's on comp, and then Tom's problem after he is no longer qualified.

The first of those would be some form of continuity, where you just continue the benefits out. I guess the mineworkers must have a year after they are laid off, or something; so just continue it out even longer than that. That means, of course, you are taking a certain large set of benefits, in many cases, and running that large set of benefits out over a long period of time, and there are some costs involved that have to be paid for somewhere.

But another approach, of course, is after some period of continuity to in effect have a somewhat lesser set of benefits, but a set of benefits that does cover hospitalizition, doctor, emergencies—the kind of situations that Tom's wife finds herself in—which is less costly.

Let me just ask you if you have any sort of built-in problem with looking at that second approach, even if we were to move in the direction of some continuity as well as the kind of proposals that we have here.

Mr. DENISON. Well, I would say I think we would want to be sure that there was a certain floor, a certain basic benefit program in place, which concerns us in the present legislation because we don't think the money is there for such a basic program of what we consider would be a minimum. So we would want at least that much spelled out.

On the other hand, the matter of the continuation of benefits through the employer—while we certainly are gratified that the miner from Pennsylvania had a year's coverage, nontheless that year of coverage came as a result, again, of collective bargaining.

If you take in employer who is not in a collective-bargaining situation and is not providing these as a cost of doing business, he in effect escapes this responsibility. But a responsible employer is assuming a burden here, as that mine company has—Bethlehem, or Jones & Laughlin, or whoever it happened to be.

That is a concern of ours, because that too affects collective bargaining at some stage in this process, because there are only so many dollars on the table. The employer goes to the next bargaining session and says, "I'd like to help you, but this legislation requires that I must provide for the people who have been laid off," and that takes dollars off the table.

The fellow down the street who is nonunion and never has been doesn't have that responsibility. So that is an area that we have concern about.

The CHAIRMAN. Ray, I haven't had a chance to read your entire statement, but I wonder if you have information on to what extent our States are currently requiring employers to offer a continuation of coverage for unemployed workers. Do you have that on a State basis?

Ms. IGNAGNI. I think, Senator, about one-half of the States are doing that presently.

The CHAIRMAN. About one-half of the States?

Ms. IGNAGNI. Yes, according to our information.

The CHAIRMAN. We may have the specifics, but if not and if you have it, maybe you could furnish it for the record.

Ms. IGNAGNI. Yes, sir.

[The information follows:]

Twenty-three states now require continuation of group health insurance benefits. Time limits for this benefit range from one to 18 months, although Florida, Georgia, Massachusetts and Minnesota have no limitation on their continuation period. For the most part, state continuation legislation includes the following provisions: individuals have 31 days to exercise their continuation option; only persons continously covered by a group policy for the three months immediately preceding coverage termination are eligible for this privilege; continuation is not required if the individual is eligible for or covered by another similar policy (Medicare, private health insurance or a similar federal or state program) and the person electing to continue coverage pays at the former group rate, but must also pay the employer's share of the premium.

The CHAIRMAN. We have just been discussing—you have with Senator Durenberger, and then with Tom as a previous witness—about two groups. We have those who are working now who are going to be out of work, and then we have those who are currently unemployed. And in the first case, where they are offered continuation, that's going to be very helpful. But in the second instance, the time for continuation has passed. What we are trying to search for is how do we deal with this second group.

You may have made more specific recommendations; I know you commented on the various proposals. But is there anything else you would want to add that may not be in your written statement?

Mr. DENISON. No, other than what all of the witnesses have indicated—speed is of the utmost importance here, as the problem becomes more acute every day.

The CHAIRMAN. Now, do you indicate your support for insurance pools?

Mr. DENISON. No. State insurance pools?

The CHAIRMAN. Yes.

Mr. DENISON. No, we would not be supportive of that program.

The CHAIRMAN. We are advised that in Connecticut, for example, the rates for such coverage are set at about 125 percent of the rate for a small group plan. And that amount can be quite large.

So you are not supporting insurance pools?

Mr. DENISON. No.

The CHAIRMAN. I guess you are also recommending, as Dr. Strain recommended, that we do more on the children's side as far as visits are concerned?

Mr. DENISON. Yes. In that area we would be interested in adding to your bill some provision for grants to the hospitals, to the public hospitals, to enable them to have that flexibility to work in this area.

The CHAIRMAN." DO YOU HAVE ANY FEAR AS HAS BEEN EXPRESSED BY SOME THAT WE MAY CREATE SOME DISINCENTIVE HERE? THAT PEOPLE WON'T WANT TO GO BACK TO WORK; THEY ARE GOING TO HAVE THIS EMERGENCY COVERAGE, SO THEY ARE GOING TO ALL WANT TO JUST SAY, "WELL, THIS IS WHAT I WANT."

Mr. DENISON. No. I think if you go to any unemployment lines, these lines that now have 5,000 or 6,000 people applying for 100 jobs, and those people are told that tomorrow they are going to get

some sort of health coverage if they don't go back to work—I think the lines would still be there. I don't think they would all go home and forget about seeking a job.

The CHAIRMAN. And there are some who will say, "Well, this is going to discourage employers from offering continued-benefit protection. Do you see that as a problem?

Mr. DENISON. Well, I think it could be. I think it would raise a flag, yes, because it has to be a cost factor.

The CHAIRMAN. I think you are right. The first doesn't concern me at all. I can't believe that what we would hope to do would have any impact on that. Well, for the previous witness, anyway; he would like to go back to work.

Mr. DENISON. And he had coverage for a year.

The CHAIRMAN. That's right.

Mr. DENISON. Excellent coverage, too.

The CHAIRMAN. But in the second part of that question, I don't know how we avoid that possibility.

Mr. DENISON. Well, that's why we've said we're not sure ourselves, and we would like to look at that a little further. That's why we just raised the flag.

The CHAIRMAN. Well, we will be working with you as we try to put something together. And I won't get into the other, the linkage question, except they tell us every Sunday that those who have a lot ought to give to those who don't have much at all—when I'm there on Sunday.

Mr. DENISON. I am not sure who you mean, who "those who have a lot" are.

The CHAIRMAN. Well, some of them have more coverage than they need, and some don't have any at all.

Mr. DENISON. Yes, but generally when the unions negotiate a program there are so many dollars on the table, and so they spend those dollars in the way they think they would get the most return. And I don't think they would then negotiate some kind of frivolous health coverage—a trip to Miami to make sure you get through the winter, or that sort of thing—but they would have so many pennies or dollars on the table, and they would move them around in the pension and wage and health care areas.

The CHAIRMAN. Yes, but there is some advantage in moving them around in these fringe areas where there is no tax to the employee or it is deductible to the employer.

Mr. DENISON. Generally speaking, my experience with collective bargaining is, the biggest pressure on a union negotiating team is to put the money up front and to pay it out in wages. And it takes, often, a lot of selling to talk in terms of benefits that are not immediately in front of one, particularly if the workforce is young, single, healthy, they "never are going to get sick." It's much easier to say, "We got you a big wage increase."

The CHAIRMAN. Well, we understand that one area may be a bit controversial. I'm not certain what will happen, but it's an area that I think we at least should consider. It can't be any more controversial than withholding.

Mr. DENISON. My deepest sympathy on that one.

The CHAIRMAN. Well, we're not finished yet. Don't bury me on that one. [Laughter.]

Mr. DENISON. Good, glad to hear that.

Senator DURENBERGER. Mr. Chairman, would you yield for a comment before the Senator from Iowa asks his questions?

The CHAIRMAN. Yes.

Senator DURENBERGER. I just have to say something for America and American health care in response to the part of Ray's statement that says every other country in the world except South Africa says health care is a right.

I dare you to find a lot of those other countries in which kidney dialysis is a right, or artificial hearts are a right, or artificial hip joints, or organ transplants.

The only right you have in a whole lot of these countries around this world is to stand in line until some doctor decides you're going to get a this or you're going to get a that.

I think there are a lot of Americans who wouldn't care to live in a place like Great Britain where you wait 2 years for surgery because the whole system is rationed out. And, yes, you may eventually get it; and, yes, we may have some deficiencies in our system in this country; but I think we come a lot closer to providing for the health care of our citizens in our imperfect very expensive way than they do in most other countries in the world. We may disagree on that, but I wanted to be on the record on that point.

Mr. DENISON. Well, it may be a hybrid, I don't know. But at least in the other countries those persons who are unemployed do have available to them health care when they need it, and in emergency cases immediately, I'm sure.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. Mr. Chairman, I just came to hear the testimony, and I have a statement that I want to insert in the record. So could I have permission to do that?

The CHAIRMAN. Sure. I'd be happy to put it in bold type if you don't read it. [Laughter.]

Senator GRASSLEY. Thank you.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF CHARLES E. GRASSLEY

I commend the chairman and my colleagues here today who have taken the lead in developing workable solutions to a serious problem. We are all very much aware of the devastating impact unemployment is inflicting on individuals throughout the country. The trauma of unemployment is incredible in and of itself without the further complication of lost health care benefits. The situation is critical, and while we all hope it to be short in duration, we must nevertheless look for ways to alleviate the burdens faced by the unemployed.

Since those who are unemployed are often the last to reap the benefits of economic recovery, we cannot ignore their plight as it exists today. Any unemployed person's financial situation is weakened by even a brief hospital stay or by a few visits to the doctor's office. Medical bills quickly add up, and the combination of o job, and no health insurance lead to astronomical financial hardship and strain on the entire family.

As this committee looks for the appropriate method to provide some relief to the unemployed, I hope we can proceed with some degree of caution and restraint. The problem is serious and cries for action. Yet, we all hope this situation to be temporary, and we cannot afford to create another permanent and expensive entitlement program.

We are currently struggling with an out of control budget, this committee should not do anything to further exacerbate that situation. We can formulate a workable and reasonable remedy to address the problem at hand, and indeed, we have a responsibility to do so.

It is obvious we have a great deal of concerns to balance, and I am anxious to hear the observations and suggestions of the witnesses on how best to reconcile such concerns.

The CHAIRMAN. Is there anything else? As I indicated, it is our hope that we can start putting something together after we have had our witnesses today and the administration presentation next Tuesday, because time is of the essence.

As you know, there are efforts being made on the House side on a somewhat different approach, so perhaps if everybody is willing to make some contribution we can work out maybe not a perfect solution but a satisfactory approach.

Mr. DENISON. We will look forward to working with you.

The CHAIRMAN. Thank you.

Now, it is my understanding that the next panel, Mr. Dickler of the Health Insurance Association and Mr. Cardwell, are not present. Is that correct? I think from here on they were told to come back at 1.

So we will now stand in recess until 1. We have three panels remaining. Thank you very much.

[Whereupon, at 11:38 a.m., the hearing was recessed.]

AFTERNOON SESSION

Senator DURENBERGER. Our next witnesses will be a panel consisting of Mr. J. Martin Dickler, actuary, Health Insurance Association of America, Washington, D.C.; and Mr. J. Bruce Cardwell, executive vice president, Blue Cross/Blue Shield Association, Chicago, Ill.

Gentlemen, your statements will all be made part of the record, and you may summarize them within the 5-minute proscription, or whatever other limitation you work out for that.

Welcome.

STATEMENT OF J. MARTIN DICKLER, ACTUARY, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, D.C.

Mr. DICKLER. My name is Martin Dickler. I am an actuary with the Health Insurance Association. With me today is Jim Dorsch, Washington counsel to the HIAA. We are here to talk about the problem of health insurance for the unemployed.

We are concerned, as you are, with this problem. Most people in this country get their health insurance through employee group policies. When unemployment extends for protracted periods of time people are deprived of something which is very valuable to them.

Basically this is not a new problem and there are four main ways in which our health insurance industry has developed techniques to help employees in between jobs. Traditionally, when unemployment is not too high, this is a problem of tiding the employee over until he secures other employment.

The oldest technique we have is the group conversion policy. Briefly, I would characterize that as good basic coverage, which is historically available without medical evidence of insurability, provided the conversion is made within 31 days.

This is an extremely important right, because terminating employees might have one or more family members or himself who have become technically uninsurable. But the insurance company must still issue a conversion policy.

In recent years there have been seven or eight States, and I think even more now, that require a group conversion major medical policy, if the group policy had that kind of coverage.

This technique has worked very well over the years, to tide employees over in between jobs. However, the employee must pay for the coverage. Now, for people who are only 3 or 4 months between jobs, this is probably and evidently has not been a great problem. But when you are out of work for 6 or 8 months, or even longer, the premiums can be onerous.

Another device that has developed in recent years is continuation under the group policy. It can happen two ways: It can be a union negotiated benefit, as it is in the auto steel and other unions, where employees on layoff may have up to 1 year and sometimes up to 2 years of continuation under the group policy. Some other employers do this voluntarily for laid-off employees. There are about 13 States that require that all group policies issued in their States have some provision for a continuation of 3 months, 6 months, 9 months on layoff.

Senator DURENBERGER. How many States?

Mr. DICKLER. About 13 or 14, Senator, at any one time. Some States have legislation pending on this. It generally applies to group policies issued in the State. So it's good, but it doesn't really speak to all residents of that State.

The third alternative to terminated employees, if they are insurable, is to buy insurance on the open market. This gives them a very broad variety of coverages and companies to choose from. The problem there, again, is that it is employee-pay-all, and it can get expensive if this has to be the main source of health coverage for an extended period of time.

A fourth alternative which is only available in six States at the moment, and is being formed in a seventh State is what is known as the State pool for the uninsurables. Really, this concept is designed for a different purpose, to provide some coverage for people who are totally uninsurable. And yet in these States, it is an obvious option as a group conversion policy, if an employee terminates coverage and, for reasons known to himself, wishes to avail himself of that coverage. Again, it suffers from the problem that it is the employee who pays the premium.

Looking at all of these methods, in good times we seem to have functioned fairly well. In bad times such as we are in now, where people are out of work for long periods of time, the question as to who pays for this is really of utmost importance. We do have these mechanisms in place.

We have reviewed some of the pending bills in the Senate—S. 307 and S. 951, which of course attempt to deal with the situation. Each differs tremendously.

Before I get into those, I might say that if all those who are unemployed or on layoff were to get good comprehensive group coverage for 12 months, we are probably talking about $2 billion a year,

roughly, after you take out those who can get coverage under their spouses' insurance.

So it is a very expensive proposition. We feel that S. 307 is an interesting bill. That would probably cost $1 to $3 billion, depending on how the 180-day continuation provision limited eligibility. That is a key characteristic of that bill which would have a broad impact on the cost.

Under S. 951 there is no 180-day continuation provision, but there is a control on cost under that, because it is linked very closely to the medicaid scale of benefits and the medicaid level of payments to the providers. That bill we feel, very roughly, might cost about $3 billion for a full 12 months of coverage if everybody eligible for it took it. That's at December 1982 levels of unemployment. Happily, as unemployment goes down, I think these cost estimates would also go down.

This is a very broad view, Senator, of how we see these shaping up. I think we see this as a cost problem, primarily and our Association is interested in helping in any way we can.

Senator DURENBERGER. Before we go to Mr. Cardwell, would you just clarify in my mind the $2 billion figure?

Mr. DICKLER. Yes. That would be for employees laid off. If you took the number of employees laid off and took out from that the number who have continuation under their group policies, then also take out those who probably can get covered under their spouses' insurance, and you then have a hard core of those who were laid off without insurance. If you gave them a full year's comprehensive major medical program at a typical nationwide group rate, you are probably talking about $2 billion.

Senator DURENBERGER. Thank you.

[Mr. Dickler's prepared statement follows:]

STATEMENT

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

HEALTH INSURANCE COVERAGE

for the

UNEMPLOYED

Presented by

J. Martin Dickler

Before the

SENATE FINANCE COMMITTEE

April 21, 1983

My name is J. Martin Dickler. I am the Actuary with the Health Insurance Association of America and appear today on their behalf. I am accompanied by James A. Dorsch, Washington Counsel for the HIAA. The HIAA is a trade association of approximately 320 companies which together write over 85% of the country's commercial health insurance.

We are pleased to have this opportunity to explain the types and extent of health insurance coverage available to people who are laid off or otherwise terminated from employment.

Most people in the United States obtain their health care coverage through their employment as a so-called "fringe benefit." More than four-fifths of those insured in the private sector are covered in this fashion. Thus, during periods of recession and high unemployment, concern increases as to how employees who lose their jobs can continue to be protected. Insurance companies offer a variety of options under which health care protection can be continued for the individual and his family. The major problem lies with who will finance the premiums and for how long.

There are a variety of mechanisms for continuing coverage. They include the group conversion provision, temporary continuance under the group insurance policy, the regular insurance marketplace, and state pools for high risk or uninsurable lives. Let me explain.

Conversion Privilege

The most common mechanism is the group conversion policy. It has been offered by group insurers for many years.

Many states require that a conversion privilege provision be included in group policies issued in their state. Most insurers offer a conversion privilege in all group policies, whether or not required by state law, to provide continued insurance protection when employment-based coverage ends. The terminated employee either needs protection temporarily until group coverage is available at new employment or a regular, longer-term individual policy because of other circumstances. In either case, the group conversion policy is issued without medical underwriting, providing that application is made within a prescribed period (usually 31 days).

This is an extremely valuable right, since the employee or his dependents may be in poor health. The insurance company is obliged to issue insurance regardless of their state of health, the only qualification being if there would be an overinsurance situation because of other coverage the employee has.

Historically, group conversion policies provided basic hospital and surgical benefits on a scheduled basis. In recent years, several states have passed legislation setting minimum standards for

benefit levels provided under group conversion policies. These have greatly increased the scheduled limits available under basic coverage. Also, about 13 states now require that a group conversion major medical policy also be made available, if the group coverage was major medical. These policies provide protection for both in- and out-of-hospital expenses, and feature high coverage limits. These policies are also issued on a non-medical basis if the employee makes timely application.

It should be noted that employer and union self-funded benefit plans are not subject to state regulation (per ERISA, Section 514) and, consequently, do not have to offer a conversion provision. However, many self-funded plans do include a conversion privilege and have made arrangements with their administering insurance company to provide it.

Continuance (Temporary) Under the Group Insurance Policy

In recent years there has also been a trend toward increased use of the employer's group policy to extend options available to terminated employees.

Customarily, employer contributions for coverage extend to the end of the month following the month in which active employment ceases. Some unions, notably Steelworkers and Autoworkers, have

negotiated continuation of employer payments for up to an additional twelve months following layoff.

Beyond this, many benefit plans provide for insurance to be continuable under the group policy on payment by the individual of the required premium. In recent years, there has been a trend towards increased use of the group policy to extend such options available to laid-off employees. At the end of this period, usually one year or less, the employee may then choose a group conversion policy. Thirteen states currently require some form of this extension under group policies.

The Conventional Insurance Market

Also, upon leaving employment, an employee may elect to purchase individual or family health insurance coverage in the conventional insurance marketplace of insurance carriers, Blue Cross/Blue Shield plans, and HMOs. A broad range of policies is available from insurance companies, subject to their underwriting requirements. Some companies offer short-term, temporary coverage (of 3-6 months duration).

Guaranteed Availability of Health Insurance

Six states provide persons who are uninsurable or in poor health an additional option. Connecticut, Rhode Island, Indiana,

Minnesota, North Dakota, and Wisconsin have created associations or state pools to issue individual insurance policies to such persons. A seventh state, Florida, is in process of formation. This type of arrangement can benefit not only terminated employees who do not elect a group conversion policy, but in fact any resident of the state employed or otherwise. This is an important development in removing barriers to health insurance protection.

We would like to set up programs in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals at no cost to the federal budget. However, ERISA is a major barrier to our seeking state laws setting up these programs. ERISA preempts state laws to the extent those laws require self-insured plans to participate in the state pools. Thus, self-insured plans are effectively shielded from the economic burden of the pools, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. We feel strongly that all competitors in the employee health benefit market should share proportionately in any pool losses. The problem could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility.

These programs are particularly pertinent at this point since all laid-off employees are not indigent and establishment of these state programs would not have an adverse impact on the federal deficit.

The Current Problem

These mechanisms work reasonably well during good times, when people who leave one job are generally able to find another within a reasonable period of time. But, during periods of high unemployment, when unemployment may last for extended periods and millions of families may be involved, serious problems are posed in terms of who will pay the premiums.

It may be helpful to estimate the magnitude of the costs under discussion. As a rough first cut, we think we are talking about something on the order of two billion dollars per year to continue health insurance coverage for up to 12 months of layoff. This is based on 2.5 million employees on layoff as of December 1982 (Bureau of Labor Statistics), reduced by estimated adjustments (1) for two wage-earner families where the other spouse's employment continues and (2) for employees whose employers will continue to pay for their health insurance beyond the customary one and a fraction of months following layoff. If we based our calculations upon the 7.3 million employees who had lost their last jobs, which includes the 2.5

million on layoff, we believe the corresponding cost for a full year of coverage would be about $6 billion.

Senate bills 307 and 951 represent approaches to providing health insurance benefits to the unemployed. There are important differences between the two which will affect the costs of the two programs. Under S. 307, the cost of the program will depend on the extent that deductibles are used, as the proposal permits deductibles of up to $500. Another important variable is the extent to which the 180 days continuation under the group policy requirement reduces eligibility for the program. Cost estimates are therefore very difficult; but on a rough basis, we would expect a cost of $1 to $3 billion for those who become eligible, if all were covered for a full year.

Under S. 951, there are savings stemming from the linkage of the benefits and provider payments to state Medicaid programs. For those eligible, who do not have other available group coverage through a working spouse, we would roughly estimate a cost of $3 billion if all were covered for a full year

We have some additional comments on S. 307 and S. 951 which we believe should be brought to your attention.

With respect to S. 307, we note that the pools would be required to offer three plans. Generally speaking, one plan would be preferable to avoid adverse selection. We also note that a self-insured

state or local government employer could remain outside of the pool. Since state and local governments are today large employers, this may cause some to switch to self-insurance and adversely affect the financial operation of the pools.

Under S. 307, the intent seems clear to include self-insured employers in the state pools. We would note that this is an essential requirement. In Section 5, an exemption from participation in the pool is permitted for a group plan provider that provides certain extended coverage under the group policy. Section 5 presents problems, since it appears to provide opportunities for an employer to select against the pool, especially when there are no federal funds payable. We urge that more study be given to this provision to ensure that it does not become a loophole that could impair the successful operation of the pool.

With respect to S. 951, the coverage of hospital and physicians' services should be defined to include diagnostic X-ray and laboratoryservices and radiation therapy, if essential services are to be included.

With respect to federal payments under the proposed program, we note that the maximum amount of federal funds that may be paid to any state is a funtion of unemployment levels, and not the level of medical care costs in the state. This could present financial

problems for states that have substantially higher-than-average medical costs, even under Medicaid payment levels.

As a final comment on S. 951, an employer would have to add parents to the definition of dependents under his group plan in order to accommodate an employee's parent who lost his or her job. We believe this is an oversight, since it is extremely unusual for parents to be included in group insurance dependent definitions. We recommend that and legislation make clear that the existing dependent definition under an employer's group plan need not be changed.

In Conclusion

The HIAA is one of six national organizations that participate in a coalition, under the leadership of Harvard Professor and former Labor Secretary John Dunlop, which is addressing the problems of health care for unemployed persons. In addition to the HIAA, other organizations include the AFL-CIO, American Medical Association, American Hospital Association, Blue Cross and Blue Shield Associations, and the Business Roundtable. The coalition has suggested that the hospital and medical associations encourage their members to meet with business, labor, insurance, and other concerned groups to determine the extent of the problems in their local communities and to explore joint solutions.

Again, HIAA and its member companies share this Committee's concern over the plight of the unemployed. We appreciate the opportunity to present this explanation. I will be pleased to respond to questions.

Background Facts

Group Conversion Policies

Most states require a conversion provision in group policies issued in their state. Most insurers include a conversion provision in all group policies, whether or not required by the state in which the group policy is issued. Self-insured employers usually have their carrier issue conversion policies even though no group policy is in force. Group conversion policies are issued non-medically, provided the employee applies within a presecribed period (usually 31 days) after termination. The employee may insure himself and eligible dependents. Most policies are guaranteed renewable, i.e., cannot be cancelled by the insurance company. An insurance company does not have to issue a conversion policy if the terminating employee happens to have other coverage and would be over-insured.

The types of coverage are as follows:

a. Basic Hospital and Surgical.

These policies cover hospital room and board up to a specific dollar limit for a specified number of days (usually 30, 70, or 120 days). Hospital special services are covered at actual charges up to a specified limit, (e.g., ten times the room and board

daily limit). Surgical charges are covered up to scheduled amounts. Several states have established minimum standards with respect to the room and board limits and surgical schedule maximums.

b. Major Medical.

About 13 states require that group conversion major medical policies be offered if the group policy provided major medical coverage. These policies cover both in- and out-of-hospital expenses typically included in major medical policies, except that some expenses such as room and board and surgical are subject to inside limits. In most states, a $500 deductible applies, or base-plan benefits if higher. In seven states, a $100 deductible is required.

Since group conversion policies are issued non-medically, they appeal to terminating employees whose health has deteriorated. As a result, claim experience under group conversion policies is higher than under standard underwritten policies with comparable benefits. As an offset, however, there is an expense savings since either reduced or no commissions are paid on conversion policies. Some companies require the employer to pay a group conversion charge when a terminating employee buys a conversion policy. This charge helps defray the cost to the insurer of providing the conversion privilege.

STATEMENT OF J. BRUCE CARDWELL, EXECUTIVE VICE PRESIDENT, BLUE CROSS/BLUE SHIELD ASSOCIATION, CHICAGO, ILL.

Mr. CARDWELL. Mr. Chairman, I am Bruce Cardwell, executive vice president of Blue Cross and Blue Shield Association. I, too, would like to think and report to you that the private health insurance industry, together with employers and with providers, could meet the needs of the unemployed at this period. It is quite clear that we cannot, and I think that it is appropriate for this committee to be entertaining questions of Federal intervention.

I think our comment to you would be that we think that intervention should be limited. We see bills like S. 951 as being we think quite appropriate to the problem, and as I make my comments I will try to confine them to that bill, but at a point or two I may refer to some of the other bills under consideration.

Our experience tells us that through Blue Cross and Blue Shield and also through a good deal of the coverage offered by the commercial carriers there are opportunities for individuals who have been laid off to avail themselves of insurance of one kind or another in many cases.

But it all comes down to the question of whether they can afford to pay the premium. There is no coverage offered without a premium, and that in the final analysis becomes the most critical question that the individuals have to face as well as those of you who are trying to fashion a program to bring them assistance.

As we look at S. 951, we think it's approach to decentralization of the management of the problem is the right approach. We have a very serious concern, though, with those provisions that talk about the utilization by the State agencies of private carriers and/or providers. As we read the bill, that seems to be suggesting that those relationships would be either entirely confined to or largely confined to administrative relationships—the employment of carriers as administrators or managers. We think that if you limit the bill in that way you really will miss an opportunity to build on those instances where the local community—the carrier, the providers, and in some cases the employers as well—are either taking action or are prepared to take some action on their own.

As I will report to you in a few minutes, some of our plans are taking steps to offer limited coverage for limited periods of time. If a State agency could buy into those programs, they could take advantage of what in effect is a cost-sharing feature that is inherent in those programs: The provider puts up some of the difference, the unemployed individual puts up some of the difference, and the health insurance carrier puts up some of the difference.

I don't think you should overlook those opportunities. I think you should make these provisions in the bill as flexible as possible and design them in a way that would encourage the utilization by the State agency of those opportunities.

At the risk of being gratuitous or presumptuous, we are not at all sure about the use of the uninsured unemployment rate as it is defined in the bill, and whether it does produce a workable and equitable measure of unemployment, and whether it will function

effectively in identifying those pockets of high unemployment within States.

We are concerned, for example, that you might have an average in a State that would fall below the threshhold and therefore not allow the State to participate. But you could have isolated pockets of very heavy unemployment, and they would be bypassed.

In the explorations that Blue Cross and Blue Shield plans have undertaken to design special programs in this area, they have reached some fairly uniform conclusions. One is that you have to limit benefits. And to that extent, your bill, S. 951, certainly follows that lead, and we think it is directed on the right path.

We, too, would call to your attention the fact that this kind of coverage invites very high utilization. We shouldn't close our eyes to that probability, and you should be aware that you are inviting a very heavy cost. We are not sure, either, that the cost estimates that you are using are the right ones, but we commend that to you for further attention.

I would like to touch very briefly on some highlights of Blue Cross and Blue Shield plan activities in this area. These include arrangements with employers and unions to extend coverage for a year or more in some cases, and in some of these cases the employer would pay all or a part of the premium for the former employee. This approach would provide continued access to group benefits for such employees.

In other cases, with employer concurrence, some plans have allowed employed persons to convert from single to family coverage if their spouse has lost coverage because of a layoff.

All Blue Cross and Blue Shield plans offer laid off individuals an opportunity to purchase continued coverage on their own behalf; but, as I pointed out earlier, the central question there is whether the individual can really afford to pay the premium.

There are plans that offer nongroup coverage that can be purchased by the unemployed. In an effort to reduce the cost of such coverage, a number of our plans have begun to develop limited benefit packages. Two such examples can be found in West Virginia and in western Pennsylvania.

That concludes my remarks, Mr. Chairman. We will be open to any questions that you might want to ask.

Senator DURENBERGER. Thank you very much.

Let me go back to the cost of what we are proposing. I think both of you have indicated you evaluated our bill. Assuming that everyone eligible to use it uses this sort of a proposal, and assuming that the States put this program to work with a combination of premium cost-sharing and the other kind of cost-sharing that we have permitted them to do, what are the dollars involved in S. 951, and what is the function and how concerned should we be about the IUR trigger? Or don't we even need that $750 million? Or do we really need much more than that? Am I making myself clear?

Mr. CARDWELL. I understand what you are saying.

Senator DURENBERGER. Do you want to answer it?

Mr. CARDWELL. Well, I would try to comment.

We do not have any precise cost estimate of what might be incurred if S. 951 were implemented. I really couldn't make a guess.

We were trying to call your attention to the unknowns that are in the nooks and crannies and in the background of this subject. One of those unknowns has to do with utilization.

We know from our own experience on extended coverage that persons who are unemployed and enjoy extended coverage have a very high utilization rate. Their very circumstances invite them to use services that they wouldn't otherwise use.

Senator DURENBERGER. They've finally got time to go to the doctor.

Mr. CARDWELL. They have time to go to the doctor, and they are also fearful that if they don't go now they might not be able to go later. And I think that latter factor is probably the most important.

You have to start somewhere, and the 750 certainly is a starting point. I guess what we were trying to say is: Beware. You could find that in the final analysis it will cost you more if you want to carry the program forward on an equitable and uniform basis.

The way you have designed the threshold trigger, it tends to limit utilization. If our analysis is correct, and it may not be, and you do bypass those political subdivisions of the State that happen to have extraordinary high unemployment, although the State average is below the threshold, by bypassing them you have not committed any Federal money. If you were to adjust the formula to be sure you pick them up, you would increase the price tag. Whether your base price tag is the right one or not, I think that is a question. We don't have an answer for you.

Senator DURENBERGER. Mr. Dickler?

Mr. DICKLER. Our estimate, Senator, would be as to what the whole program might cost, regardless as to how much would be Federal funding and how much would have to come from the States—or, for that matter, from the employee——

Senator DURENBERGER. And that was the $3 billion you testified to?

Mr. DICKLER. That's right. And that's an awfully hard one to figure, Senator, because there are so many variations in the State medicaid plans around the country, as you know.

Senator DURENBERGER. But we have a uniform set of benefits.

Mr. DICKLER. Well, it seems to me it would track the Medicaid benefits in the State in which the program applied.

Senator DURENBERGER. Not in our bill.

Mr. DICKLER. In other words, if it was hospital and physicians services, but subject to the laws in the State.

Senator DURENBERGER. Oh, I see.

Mr. DICKLER. And its maximum.

Senator DURENBERGER. I understand.

Mr. DICKLER. We didn't have time to make an exhaustive review of all of the variations that might be around, so I made a broad estimate as to what it would be and came up with the $3 billion. If the Federal moneys in that were $750 million, the Federal contribution, then the balance would have to come from the States and from the employee contribution itself.

But the likelihood of everybody participating? It is difficult to say. The likelihood of everybody staying in for 1 full year is diffi-

cult. I suspect that would be a big reason why the $3 billion would be an outside figure.

These are order-of-magnitude, Senator, not done with a slide rule, but I don't think it would exceed $3 billion for a full year of the program.

Senator DURENBERGER. We really have two kinds of people that we are talking about here. Our bill touches one, but in part the other. We are talking about people who are currently unemployed, and the other group is people who are currently employed but might be unemployed after we pass this kind of legislation. And we may be able to go beyond where we are now, for people who are currently employed—in other words, go beyond the recommendation of open enrollment into something else, some other form of mandated continuity or something else.

Among the various things that you talked about that the States are doing—conversion, group conversion, continuation, State pooling, that sort of thing; I think you went through that list—would you have a recommendation for us as to which approach might be better for us to encourage, given an effort not to raise the cost of employing people in this country, given efforts to try to minimize the tax obligations that come out of this process? What should we be looking at in terms of the private sector here?

Mr. DICKLER. Well, I think that probably the most efficient or effective method of limiting the expense, from the back end of it, would be a continuation requirement for coverage under a new policy. You have that in many States in varying degrees, but it is by no means the rule of the land.

I think S. 307 with its 180-day requirement exerts a very powerful restraint on the cost of the program because of that feature. I don't know whether 180 days is the right number or not, but the notion behind that I think certainly would restrain cost overruns or——

Senator DURENBERGER. Have you some idea of the costs that are involved in, say, the 180-day provision, nationwide?

Mr. DICKLER. Oh, yes. That's a good half-year's coverage. Well, around the country today, even at group rates, for a comprehensive major medical program which is a complete program, you are probably talking $700 to $800 a year for an individual and $1,800 to $2,000 a year for a family. So a half-year's coverage, Senator, in very round numbers, is like a $1,000 per family, and maybe $400 for an individual.

Senator DURENBERGER. And that contemplates what kind of a benefit package?

Mr. DICKLER. That would be what you would generally find in the country, a comprehensive major medical plan, where you have full hospitalization benefits, physicians services, surgical services. They would pay 80 percent of the reasonable and customary fees. There might be a deductible of $100. But the plan would include prescription drugs, private duty nursing, durable medical equipment, prosthetic appliances, ambulance, similar medical services such as that. This is a very common form of coverage today.

Senator DURENBERGER. Does that appear to be the trend in this country? Do you try to move in the direction of some form of continuity?

Mr. DICKLER. Up until a few years ago, basic plus supplementary major medical coverage was the rule. "Basic coverage" meaning all first-dollar hospital and surgical, and then a supplemental major medical plan.

I would say in the last 5 to 8 years comprehensive major medical has come into popularity, although that also in recent years has had a good measure of first-dollar hospitalization coverage; in other words, the deductible doesn't apply to the hospitalization.

Senator DURENBERGER. And that, in effect, gives us a situation where employed people are financing coverage for unemployed persons?

Mr. CARDWELL. That is correct.

I do not agree with that level of coverage as the appropriate solution to extended unemployment. I don't think it's affordable. I think it shifts too much of the burden back to the employer for the long term.

While I agree with the idea of open opportunity and full opportunity for extended coverage, including the original group coverage, leaving to the individual the choice as to whether he can afford to do it once he's unemployed, I think there also have to be opportunities for lesser benefits at a lower unit cost to both the unemployed person, perhaps through cost sharing, but certainly to the person who pays the ongoing premium. I think we have to work to lower the cost of employment, and I think we have to be very careful.

Senator DURENBERGER. Well, the chairman of this committee and I have a little proposal that does that—it's called a tax cap. The suggestion has been made more than once that we tie the cap to this benefit.

Do either of you have any comments on how that might work? In effect what we would be doing is something like this, where we might be lowering the cost to employers by changing the mix and the role that the employee is playing in paying for that mix of health benefits, and at the same time providing an opportunity for continuity or some other form of health care during periods of unemployment.

Do you have general reactions about that?

Mr. CARDWELL. My reaction is that I guess we are in disagreement on the effectiveness of the tax cap for that purpose and whether it is the right method. I happen to think it is the wrong method.

What I was talking about was an opportunity that the employer and the employee—from which they could elect about extended coverage.

I don't see the tax cap itself as influencing that opportunity; but, most important, I wouldn't want to see the opportunity impaired. I would like to think that the employer and the employee will always have that choice.

I don't think we want to have a debate on the tax cap here today, but the point I was trying to make is we were talking about extended coverage, and I was suggesting that there be multiple opportunities—one of which should be for a lower benefit package, a smaller benefit package, a lower premium cost both during the employment period and during the postemployment period.

Senator DURENBERGER. Mr. Dickler?

Mr. DICKLER. Senator, our analyses of the tax cap came down with really two conclusions: One, that it probably wouldn't raise an awful lot of revenue because of the relative ease with which employers could pursue tax-avoidance arrangements, which would be perfectly legal; and, secondly, as a cost-containment device we thought it was highly overrated and really wouldn't serve the purpose. If the Congress went ahead and passed it anyway, you would probably raise some revenue, but probably not enough to talk about the programs we are talking about.

So I think we would have reservations that it is a real solution to this problem, that the tying together wouldn't result in the object that you have in mind.

As my colleague says, one way to control costs would be to provide lesser benefits, which would ease the burden on employers somewhat. As a matter of fact, each of these bills do provide for a more limited scope of benefits from what I outlined as current today.

Senator DURENBERGER. Well, obviously, by raising the tax cap issue I didn't want to debate it now but just to suggest that the cost of providing health care for the unemployed will vary with the tax treatment of health care in general, and the capacity of some employers to provide that will vary also.

I think it's terrific that the United Auto Workers and the Steel Workers have managed to get 1 year or 2 years' continuity on top of $300 a month premiums, and then still pay $14, $15, $20 an hour. I guess I can understand why the basic industries are going broke in this country.

But there are others who ought to be able to learn from that experience. I think probably, as we look at the issue of the tax cap, we all like to put it in the context of how do we keep down the cost of employment, and how do we find the right kind of incentives in that area to provide some restraint in how much of what goes into the so-called health insurance package, and how much do you really need? That is obviously something we have to look at in terms of long-term unemployment. It's pretty hard to keep up a $300 a month package for 2 or 3 or 4 or 5 years for thousands of people without bankrupting a——

Mr. CARDWELL. Could I add perhaps a different note to your original question about how to manage coverage for the unemployed, near term or long term?

Again, I would come back to the point that I tried to make in my opening remarks.

As we devise legislation of this kind, my observation through the years has been that we tend to work at the Federal end of the chain. We will put the money in the Federal end, and it's almost always on the assumption that the party at the very other end gets his full cost.

If there ever was a circumstance under which you wanted the various parties and participants to share, this is the circumstance.

I would again come back to fostering and leaving opportunities open for encouraging initiatives on the part of the insurance underwriters, providers, and communities to share in the cost of this problem.

Don't make it so easy. Don't just give 100 percent Federal money. Somebody has got to start giving on that chain.

Senator DURENBERGER. But there is a problem with logic here, and we probably should have Ray Denison back here to argue this logic, but we are talking about cost sharing at a time when people are out of work, and we are not talking about cost sharing when they are working.

Mr. CARDWELL. Well, if you learn how to do it when they are not working, maybe it will feed over into the time when they are working.

Senator DURENBERGER. Well, it's a lot easier to go about it the other way.

Mr. CARDWELL. I don't promise it as a full solution, or even perhaps a significant solution to this problem, but I think there are some opportunities building out there. All I am saying is, leave openings for those opportunities to find their level.

Senator DURENBERGER. Well, I don't have any problem in agreeing with that.

Any last comments?

Mr. CARDWELL. No, sir.

Senator DURENBERGER. Thank you very much. I appreciate your testimony.

[Mr. Cardwell's prepared statement follows:]

STATEMENT
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON THE
FINANCING OF HEALTH CARE BENEFITS
FOR THE UNEMPLOYED

BEFORE THE
SENATE COMMITTEE ON FINANCE

PRESENTED BY:
BRUCE CARDWELL
EXECUTIVE VICE PRESIDENT

APRIL 21, 1983

Mr. Chairman and Members of the Committee, I am Bruce Cardwell, Executive Vice President of the Blue Cross and Blue Shield Association, the national coordinating agency for the 99 Blue Cross Plans and Blue Shield Plans in the United States and Puerto Rico. Today Blue Cross and Blue Shield Plans serve about 78 million members under private programs and an additional 26 million people under government programs.

OVERVIEW

Before I begin, I would like to commend the Committee for addressing today's subject: health care benefits for the unemployed. For the unemployed who had Blue Cross and Blue Shield coverage, there have been opportunities to maintain their insurance coverage; all Blue Cross and Blue Shield Plans allow conversion from group policies to individual coverage for those who leave covered employment. In addition, most of our Plans hold periodic open enrollment during which anyone can buy coverage. The central issue, of course, is the ability of the unemployed to pay for their health care coverage. The availability of coverage isn't worth very much if a person cannot afford to pay the premiums. S.951 would provide some Federal financial assistance to the States to help address this problem directly.

There are a number of features of S.951 to which we would like to direct our comments—

-- Overall program design and implementation
-- Conditions for State participation
-- Eligibility criteria for the unemployed
-- Benefit design
-- Program cost
-- The role of the private sector

PROGRAM DESIGN AND IMPLEMENTATION

As we see S.951, it is essentially a Federal-State matching grant program with the States being given the choice of whether to participate as well as some opportunity to conform the application of Federal assistance to local circumstances. We applaud the decentralized approach to the problem.

Our concern is that, in contrast to the latitude given states in program design, the proposed legislation may define narrowly the parties with whom states may contract. As section 2008 (d) now reads, states may administer the program through their Medicaid agency or may contract, "with cost effective financing and delivery systems among carriers or providers, and may selectively contract with a specific group or provide for capitation reimbursement ..." We find this to be unclear as to whether participation by insurance carriers generally is intended. If such participation is not intended by the legislation, we ask you to reconsider. If it is intended, we ask that you clarify the potential opportunity and role for carriers. Several of our Plans are already trying some different approaches to this problem, and we would hope the Federal government would support and build on such private initiative wherever it is found.

STATE PARTICIPATION

We are not sufficiently familiar with the statistic "Insured Unemployment Rate" to assess its sensitivity as a measure of need. We are concerned, however, that if the statistic is used only as a state-wide average, it may mask localized pockets of high unemployment. We suggest that the Committee explore the extent to which such local areas might be excluded from possible assistance under this program.

INDIVIDUAL ELIGIBILITY

We are concerned by the provision of the Bill that will exclude those unemployed who had not participated in group coverage before they lost their jobs. While individuals formerly enrolled in group coverage may represent the greatest proportion of unemployed workers, this provision will exclude a substantial segment of the unemployed population. People who did not have access to group coverage while employed, individuals who worked for small employers, or who could secure only part-time work or short spells of work because of the economy, may be in the greatest need of assistance. We encourage you to allow States the option of covering all the temporarily unemployed if states can find sufficient resources to do so.

BENEFIT DESIGN

In recent months, a number of Blue Cross and Blue Shield Plans have begun to explore and in some cases develop programs to insure the temporarily unemployed. Each of these efforts has concluded that the benefit must be limited to essential services, much as the proposed legislation has done. On the basis of this experience we agree with the direction of S.951 regarding benefit design.

Similarly, if limited public funds are to stretch as far as possible, some form of cost sharing is probably necessary. But, the critical question is, just how much cost sharing can an unemployed person absorb?

A subtle aspect of cost sharing in these circumstances is that, where a premium is involved, it will produce an adverse selection spiral. This occurs because cost sharing tends to invite participation by high utilizers and to discourage lower utilizers. But even in the face of this, the imposition of premium charges will probably be unavoidable.

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PROGRAM COSTS

It is estimated that 5.3 million people have lost their health insurance coverage. The number more than doubles when dependents are also counted. Clearly, the potential enrollment in the program outlined by S.951 is great. Moreover, our experience with subscribers on extended coverage due to unemployment is that their utilization rates are about 130 percent of average group utilization. This suggests that the total cost of this program will be high — but just how high is difficult to calculate, given the voluntary nature of the program and its many variables. Whether the sums authorized by this bill will be sufficient will, of course, depend on how many and which States participate, what their program costs may be, how many of the unemployed will participate, etc.

PRIVATE SECTOR PROVISIONS

We endorse the concept of stimulating open enrollment of unemployed spouses or parents. On a voluntary basis, such open enrollment already occurs in many instances, certainly under Blue Cross and Blue Shield coverage. We also endorse the requirements for coordination of benefits, although we can tell you from experience that such requirements are difficult to administer.

FEDERAL IMPEDIMENT TO STATE BASED INITIATIVES

At this point, we should note what we see as existing federal impediments to state initiatives in this area. Many states now require all insurers to provide conversion opportunities — for group insured employees to convert to individual coverage when they leave employment. Unfortunately, due to the federal preemption (under ERISA) of state laws dealing with employee benefit plans, such state requirements do not cover the many large employers who are now self-insured. That preemption provision of ERISA is a serious impediment to most of the state oriented solutions now being proposed, including the use of state pooling mechanisms.

State pools established to deal specifically with the cost of health insurance for the unemployed could be a promising development — if all parties participated. Again, the problem with this idea is that under the ERISA exemption, self-insured employers could not be required to make an equitable contribution to the pool. It appears that Senator Riegle's proposal, in S.307, would explicitly deal with that problem. We encourage you to address the problem either now, in S.951, or in the near future. Many states may want to develop state pools as a long-run mechanism for financing health care benefits for the unemployed.

BLUE CROSS AND BLUE SHIELD PLAN ACTIVITIES

As the nation's largest providers of health care coverage, Blue Cross and Blue Shield Plans are concerned with offering adequate and affordable coverage for all, including laid-off workers. Traditionally Blue Cross and Blue Shield Plans have taken action to make available some form of post-employment coverage. These include:

- Arrangements with employers and unions extending coverage for a year or more. In some cases, the employer pays all or part of the premium. This provides continued access to group benefits, the most cost-effective way to purchase health care expense protection.

- With employer concurrence, most Plans allow employed persons to convert from single to family coverage if their spouse loses coverage because of a lay off. Again, this option allows workers to continue coverage, without interruption, and to do so through group mechanisms.

- All Blue Cross and Blue Shield Plans offer laid off individuals an opportunity to purchase continued coverage through a group conversion contract. This provides access to coverage without waiting periods or physician examinations.

- Plans also offer non-group coverage that can be purchased by the unemployed. In an effort to reduce costs, several Plans have begun to develop limited benefit packages and are considering various means of financial special coverage programs to make such coverage more readily affordable by the unemployed.

As indicated earlier, a number of Plans have begun to develop special programs to insure the large number of currently unemployed who find themselves without any form of benefits. Most of these programs are still in their early stages of development and implementation.

An example of one approach is underway in Charleston, West Virginia. The Charleston Blue Cross and Blue Shield Plan is offering a limited hospital benefit for the United Mine Workers Union. The benefit was originally designed to protect workers during the recent UMW strike. The Union, pleased with the security offered by the benefit asked the Charleston Plan and other Plans that administer this account to make this coverage available to miners who have exhausted their health and welfare benefits due to layoffs. As an important side note, the Charleston Plan has had a number of calls from local charitable organizations volunteering to help union members to pay the minimal monthly premium.

A different approach is underway in Western Pennsylvania. The Western Pennsylvania Blue Cross Plan, working with Pennsylvania Blue Shield, has filed for state insurance commission approval to offer individuals with proof of unemployment a limited set of hospital and medical benefits. To help reduce costs to a manageable level for the unemployed, hospitals and physicians will "forgive" coinsurance and deductibles. Together, the contributions of the Plan and providers will reduce premium cost to about $70 per month, per family -- compared to a regular rate for the same coverage of about $150.

In many parts of the country, physician organizations, community groups and health care providers have rallied to assist the unemployed worker secure necessary care. We believe that the federal assistance offered by S.951, if allowed wide flexibility in administration, would enable states to support such voluntary efforts where they exist, and to create new health benefit protection for the unemployed where needed.

Mr. Chairman and Members of the Committee, in conclusion, we believe Senate Bill 951 represents an important step toward assuring unemployed, uninsured workers access to needed health care services. I encourage you to consider our concerns and suggestions and to call on us if we can be of assistance to your staff in this important policy development process.

Senator DURENBERGER. The next panel consists of Mr. Don Bliss on behalf of the National Association of Manufacturers; Mr. Willis B. Goldbeck, president, Washington Business Group on Health, Washington, D.C.; and Mr. Jan Peter Ozga, director of Health Care, and Erix Oxfeld, Employee Benefits Attorney, for the U.S. Chamber of Commerce.

Gentlemen, please proceed in the order you were introduced, and your full statements will be made part of the record.

STATEMENT OF DON BLISS, ESQ., ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS, WASHINGTON, D.C.

Mr. BLISS. Mr. Chairman, my name is Don Bliss, and I am a member of the law firm of O'Melveny and Myers, but I am here today in my capacity as a member of the National Association of Manufacturer's Health Subcommittee. With me today is Sharon Canner, who is a health care analyst at the NAM.

We wish to commend this committee, Mr. Chairman, for your leadership in seeking solutions to what is now perceived to be a serious national problem: the unemployed who have lost job-based health insurance coverage.

We appreciate very much the opportunity to express the views of the NAM on this important issue.

The Health Subcommittee of the NAM has studied the proposals offered by Members of Congress and has found positive elements in each of them which build upon the private sector structure as it exists today. These elements we can support and do support.

We have some concerns with other elements of the proposals, however. We believe that the experience of the last few years teaches that in addressing problems of health care financing we should try at all costs to avoid the establishment of new Federal or State bureaucracies and regulatory regimes.

We, further, should avoid the creation of new Government entitlement programs, the addition of new financial burdens on the Federal health care budget, or the distortion of the marketplace by eliminating choice or reducing competition in health care.

All too often such well-intended Federal programs simply fuel the flames of spiraling health care cost inflation, diffuse the concentration of limited Federal dollars on the truly medically needy who must rely on Government entitlements for any medical care, and exacerbate the rising uncontrollable element in the Federal deficit which we must get under control if we are going to put people back to work—which is the real objective that would meet the problem addressed by this committee.

In today's economy, the solution we believe must be found in the private sector, and for this reason we believe that any Federal legislative solution should build upon the existing private structure and include consideration of the following elements:

First, we recognize that some 90 percent of nonfarm employees have job-based insurance coverage, health insurance coverage. For those who are temporarily laid off, the existing job-based group health plan should be extended for a period of time.

At the present, many companies offer former workers extended benefits ranging from 1 month to 2 years. We would recommend

that employers be encouraged to provide extended coverage, and that a period of at least 90 days be required as the condition of the employers' deductibility for health benefits now provided under the Internal Revenue Code.

The former employee's coverage under this extension would be maintained at the same benefit level, with the same cost-sharing arrangements that existed before the layoff.

Second, beyond the 90-day period, or longer should the employers so provide, a second phase would take effect. The former worker would have two choices during that second phase: First, he or she could continue to have the same coverage at the cost fully paid by the former employer, at group rates which would be negotiated or contracted between the employer and the insurance carrier. This would be a continuation of the group coverage plan beyond the 90-day period but at full cost to the employee.

The second option would be a low-option basic insurance package which would be provided to the employee at a substantially-reduced cost. This would provide the basic hospitalization, outpatient, physician, and some maternal and child care, but none of the extra benefits, and it would shaped in a way as to provide minimum cost to the unemployed former worker at that time.

So beyond the 90-day period you would have the two options: the continuation of the coverage at the group rate, or the low-cost option, similar to what Mr. Cardwell previously referred to in the last panel.

The third element would be: In the event that an employed worker's spouse loses a job due to a layoff, the employer of the working spouse would be required to offer insurance coverage immediately upon the expiration of the 90-day period. So we would agree that where both spouses are employed, the spouse of the working employer would be required to pick up the spouse immediately and not wait for an open-enrollment period. That requirement would be waived.

This obviously does not cover the entire problem, but 42 percent of the uninsured unemployed have a working member of the family; so it would meet a substantial part of the problem.

Fourth, to facilitate reentry of workers into new jobs, health insurance coverage at the new place of employment should be made effective no later than the 31st day of employment. Currently employees have to wait sometimes from 1 to 6 months in order to have their new health insurance take effect. But we would require that special open enrollment restrictions be eliminated under these circumstances, and on reentry the employee be provided insurance within the 30 days.

These four elements—extending coverage for at least 90 days, providing the continuation of coverage and a low option plan at that time, spousal coverage, and immediate coverage on reentry to employment—constitute a private sector approach to the problem that this committee is addressing.

The principal benefit of this approach, we believe, is the administrative simplicity of it and the use of the existing insurance structure as a basis for it.

It doesn't require the establishment of new bureaucracies and regulations and guidelines; it can be implemented immediately and

effectively to address the problems with which this committee is concerned.

We believe that this type of an approach is responsive to the committee's concerns, and it further recognizes that programs for the poor and elderly which have already been severely cut in various budget proposals—that resources for these programs—would not have to be further diminished to serve through Federal entitlements yet another group of persons in our society whose needs may be great but whose needs are not as great as those who must rely, because they have no other alternative, on Government assistance for their basic medical needs.

Thank you, Mr. Chairman.

[Mr. Bliss's prepared statement follows:]

STATEMENT OF

Donald T. Bliss, Esq.

Partner

O'Melveny and Myers

on behalf of

The National Association of Manufacturers

on Health Insurance for the Unemployed

Before the Senate Finance Committee

U.S. Senate

April 21, 1983

Mr. Chairman and members of the Senate Finance Committee, my name is Donald T. Bliss, and I am a Partner with the law firm of O'Melveny and Myers. From 1969 to 1973, I was an assistant to the Secretary of Health, Education and Welfare. I am also a member of the National Association of Manufacturer's Policy Subcommittee on Health Care. Accompanying me is Sharon Canner, health care analyst at NAM. Today I am representing the NAM, an organization of over 12,500 corporations of every size and industrial classification located in every state. Our members employ 85 percent of the workers in manufacturing employment and produce over 80 percent of the nation's manufactured goods.

We wish to take this opportunity to commend the Committee on its leadership in seeking solutions to the medical/economic problems faced by the unemployed who have lost job-based health insurance coverage. The NAM looks forward to working with you on this difficult, but vital task.

Private health insurance in this country covers 160 million workers and their families. Much of this insurance is provided by employers through group plans. Loss of employment often means loss of insurance coverage for the worker and the worker's family. A double digit unemployment rate results in a growing number of individuals who can no longer afford basic physician and hospital care. Naturally the pressure is growing for public action in this area.

The National Association of Manufacturers considers the loss of insurance coverage a grave problem. All of industry is affected by this problem in one way or another. When health care coverage for laid-off employees expires, these persons must of necessity seek care for themselves and their families through the publicly financed system, Medicaid. Companies that have not experienced job loss appear to be subsidizing health care for the unemployed. It is we, the employer community which supports that medical system through the tax dollar. Further, when individuals cannot cover medical bills through their own funds and/or insurance, hospitals, in particular, incur bad debts and the costs are then shifted to others in private sector.

In considering the health care needs of the unemployed, the NAM has studied the various proposals that have been offered by members of Congress. These proposals have meritorious objectives and their sponsors should be applauded for their efforts to alleviate the physical and economic difficulties being faced by laid-off workers. However, proposed solutions to a complex problem must not create additional administrative or bureaucratic complexities which would stifle legislative attempts to meet the needs of citizens who are temporarily without insurance coverage. Specifically, we should not create new entitlements, expand existing programs, establish 50 individual state programs or pools. Rather, assistance in resolving this problem should be sought from those in the private sector.

If it appears likely that Congress intends to legislate health care coverage for the unemployed, the NAM has prepared a set of considerations that might assist in development of such an effort. Certain basic elements are also included in this private sector approach.

CONSIDERATIONS

o The National Association of Manufacturers believes that adequate health care should be available to all legal residents of the United States at reasonable cost. Portions of our population, at one time or other, will lack sufficient medical coverage and some of these gaps can be filled by the extension of private sector plans, while others such as coverage for the poor and near poor are legitimate areas of government responsiblity, such as Medicaid. Individuals involuntarily and temporarily separated from their jobs belong to the former group and are not appropriate areas of government responsibility.

o The loss of jobs and corresponding loss of employment-based health insurance is both a current problem requiring action and may be a long term problem requiring additional measures.

o Any health care plan to aid the unemployed should seek to meet temporary basic primary care needs. Aid of this nature must not interfere with the individuals continuing the job search and return to the workforce.

o Health insurance for the unemployed should seek to continue the traditional of medical care provided to other portions of the population by offering alternative health care options. Appropriate coverage will assist the individual during this critical period of transition and furnish the support needed to continue the job search.

A PRIVATE SECTOR APPROACH

With these considerations in mind, the NAM recommends the following approach to meeting the health insurance needs of unemployed workers should legislative options be entertained.

Extension of Benefits. The starting point for this private sector approach is the existing job-based group health plan. At present, many companies offer former workers extended benefits ranging from one month to two years depending on length of service and the particular industry involved. Therefore continued coverage for a period such as 90 days could be mandated and tied to the employer's deductibility for health benefits now provided under the IRS code. Coverage given under this approach would maintain the former employee's coverage and thus would be comparable to that which is provided for other workers. The expense would be borne by the same arrangements that existed before lay-off, i.e., totally employer paid, or combined employer/employee financed.

Beyond the 90 day period a second phase would then take effect. This phase, effective for one year, would offer the former worker several choices:

(a) The option to continue the same coverage, but with the cost paid by the former worker, at group rates contracted/negotiated with the insurance carrier by the employer (special arrangements would be made for self-insured companies).

(b) Development of a "low option" basic insurance package with financing arrangements the same as (a). The intent is to give the individual (and family) basic protection at a minimal cost.

Unemployment Compensation. Title V of the Social Security Act Amendments of 1983 provides, at a person's request, for deduction of portions of Unemployment Compensation to finance health insurance. Those unemployed who voluntarily allow for a deduction from the UC benefits check could have those amounts used to cover premium costs as mentioned above under "extended benefits." However, we believe that this election should be totally voluntary and would oppose any mandated diversion of monies from the UC trust funds to finance health insurance coverage. In previous testimony before Congress, the NAM has opposed any diversion of monies from UC benefits for purposes other than as intended by UC law.

Family Coverage. In the event that an employed worker's spouse loses his/her job due to lay-off, the employer of the working spouse would be required to offer insurance coverage to that individual immediately upon expiration of the 90 day period. The premium financed by the active worker for this family coverage should be comparable to that charged for similar family coverage offered by the company.

Employment Re-entry. To facilitate re-entry of workers to new jobs, (or former jobs), health insurance coverage at the new place of employment could be made to become effective by at least the 31st day of employment. Special open enrollment or other timing restrictions should be eliminated under these circumstances.

CONCLUSION

Central to NAM's private sector approach is its administrative simplicity and use of already existing structures. A majority of companies, both large and small, provide a group health plan administrated by the company or its agent. Use of this structure to assist the laid-off worker would require no new government agency or staff to operate the program. This approach could be implemented immediately to alleviate the short term need and could continue to offer extended benefits, family coverage

and quick re-entry eligibility for the long term as well. Appropriate health insurance coverage for the laid-off worker will assist the individual during a time of difficult transition.

This approach does not create a new federal entitlement or 50 separate state bureaucracies with their accompanying administrative overhead costs. It recognizes that programs for the poor and elderly have already been severely cut and that to offer federal assistance to yet another group, although their needs are great, would be inequitable.

Thank you for this opportunity to present our views on health insurance coverage for the unemployed. We look forward to working constructively with this Committee and Congress on this and the other critical issues affecting our nation's economic recovery.

STATEMENT OF JAN PETER OZGA, DIRECTOR OF HEALTH CARE, U.S. CHAMBER OF COMMERCE

Mr. OZGA. Thank you, Mr. Chairman.

My name is Jan Ozga, and I'm director of Health Care for the U.S. Chamber. With me today is Eric Oxfeld, our employee benefits attorney and staff executive for our Council on Employment Compensation.

The U.S. Chamber believes that all Americans should have access to quality health care at affordable prices, and that programs designed to achieve this goal should stress maximum private and minimum public involvement. The Federal Government should limit its role to establishing broad, flexible, and voluntary goals for national health care that are consistent with reasonable social and economic goals of the Nation. Federal programs are only appropriate when the private sector or the states cannot fulfill an important health care need.

At the same time, the chamber remains committed to sound policies that will improve the economy and promote employment. We also remain committed to protecting the solvency of the States' beleaguered unemployment insurance fund.

It is within this context that we have evaluated the proposals to provide health care insurance for the unemployed workers and their dependents and make the following points, which are the key points in our written statement submitted for the record.

First, the problem of lack of health insurance for the unemployed will abate as the economy continues to improve and unemployment is reduced. A continuation of the trend toward a reduction in taxation, regulation, and interest rates will help to achieve the dual goal of fuller employment and protection against health care costs.

Many options already exist to provide unemployed persons with health insurance or protection against health care costs. These include: continuous coverage provisions in many employer-paid health care plans; the conversion privilege offered in many of these same plans: coverage under a spouse's or other relative's plan; and the social safety net, medicaid.

Health care and unemployment are basically State-level concerns, with corresponding programs to meet these needs. The issue of health insurance for the unemployed should also be resolved at that level, without Federal intervention. Currently, 29 States have enacted some legislation dealing with health insurance and unemployment. We advocate that the States continue to resolve this and other health insurance matters. State pools are one possibility.

We also call the committee's attention to the recently enacted Public Law 98-21, the Omnibus Social Security Act Amendments of 1983, which includes a provision that clarifies the State's right to make deductions from unemployment benefits to pay the premium for health insurance. Several proposals would build on this provision by specifying a deduction to pay for premiums and impose a deductible on individuals when billed for health care. We support this cost-conscious approach to financing health care for the unemployed.

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At the same time, we oppose Federal financing for such programs, since Federal deficits are already at record high levels. We also oppose new entitlement programs that have the potential to become open-ended. Some proposals amount to welfare programs without appropriate means tests.

We also oppose those proposals that would increase employers' labor costs. Mandating through tax penalties that employers carry laid-off workers for some specified period or open health plan enrollment to spouses, or contribute to an assigned-risk pool, would place them in double financial jeopardy. Employers' response could be to drop their health care plans altogether and/or lay off more workers.

Finally, we vigorously oppose proposals that would mandate a minimum benefit package. This requirement goes beyond the problem being addressed and infringes on the right of employers and employees to develop the kind of health care coverage they want and can afford at a time when employers and employees are being very creative in the design and are negotiating a very hard line with the providers and carriers of health care for more cost effective health care plans. Such a requirement would be particularly onerous to small businesses, which have been most severely affected by the recent recession.

This concludes my remarks. Mr. Oxfeld also has some comments on this issue.

STATEMENT OF ERIC J. OXFELD, EMPLOYEE BENEFITS ATTORNEY, U.S. CHAMBER OF COMMERCE, WASHINGTON, D.C.

Mr. OXFELD. I would like to highlight a couple of concerns relative to the impact on the unemployment compensation program of proposals for new health insurance programs.

First, we urge you to give adequate funding to the State unemployment agencies to cover any new responsibilities. Otherwise, they will have even less of their scarce resources to devote to their basic but often overlooked mission, which is finding new jobs for the unemployed.

Second, we urge you to be sure that these proposals don't take away the incentive for unemployment claimants to accept part time and temporary jobs when permanent jobs are unavailable. At present, claimants resist such jobs, because earnings from 2 or 3 days of work will often disqualify them from any unemployment benefits. If claimant lose their health insurance for weeks in which they are disqualified from unemployment benefits, they will have even less incentive to accept work when it is available.

Third, we remind you that unemployment compensation is not a poverty program. Some claimants have substantial assets. For example, 1979 income tax records reflect more than 1½ million tax returns reporting adjusted gross income of $20,000 or higher and also receipt of unemployment compensation. Moreover, when unemployment benefits are combined with other income-support programs, some claimants actually come out better than when they were working.

Our conclusion is that, given the existing Federal budget deficit, Government-subsidized, or free health insurance is hard to justify for a substantial number of unemployment insurance claimants.

Finally, I point out the anomaly that last year Congress—evidently in the belief that unemployment compensation was too high—raised the tax on unemployment compensation by taxing benefits to claimants whose earnings are either $12,000, or $18,000 if they are married.

I might add that the Chamber was strongly opposed to taxation of unemployment benefits, and we continue to take that position.

But now you are suggesting that unemployment benefits may be too little to buy health insurance. We think that's very curious.

I thank you.

[The prepared statement from the Chamber of Commerce follows:]

STATEMENT
on
HEALTH INSURANCE AND THE UNEMPLOYED
before the
SENATE FINANCE COMMITTEE
for the
CHAMBER OF COMMERCE OF THE UNITED STATES
by
Jan Peter Ozga
April 21, 1983

My name is Jan Peter Ozga. I am Director of Health Care for the Chamber of Commerce of the United States. Accompanying me today is Eric J. Oxfeld, the Chamber's Employee Benefits Attorney and staff executive for our Council on Unemployment Compensation. We are here to express opposition to new federal programs that would provide health insurance to the unemployed.

The Chamber of Commerce of the United States is committed to the encouragement of sound policies which will promote high levels of employment. We also advocate access to quality health care for all individuals.

Because 90% of group health insurance is obtained through employment, we recognize that those who become unemployed may lose their coverage. However, the extent of this problem is not clearly documented. Moreover, creating new massive entitlement programs and/or imposing costly mandates on employers who provide health insurance could lead to substantial reductions in the extensive health insurance coverage now provided through the workplace.

Increased employment will reduce the problem of those who have lost their health insurance. Economic recovery and sustained economic growth will eliminate cyclical unemployment and lead to more health coverage for American workers and their families. Current state experiments with providing health coverage for the unemployed is an available option. However, we do not recommend any new federal laws that would increase deficit spending to address this problem, and we oppose any proposals to increase employers' labor costs or add to the complexity of tax-qualifying group health benefits.

ECONOMIC RECOVERY AND EMPLOYMENT

The Current Employment Picture (March, 1983)

The population of the United States was 233 million in March, 1983.

The labor force totaled 112.1 million, up 1 million from March, 1982. This figure represents 64 percent of the adult population 16 years of age and older. It excludes members of the armed forces stationed abroad and individuals institutionalized in hospitals, nursing homes, and prisons.

Total employment was 100.8 million. Some 11.4 million were unemployed, or 10.1 percent of all workers.

During the past year, the increased unemployment of 1.5 million was caused principally by the 1 million new entrants into the labor force and a change in composition of employment, which resulted in a loss of an estimated 1.3 million blue collar jobs, while employment continued to rise for white collar and service workers.

It is estimated that some 40 percent of current unemployment is cyclical, specifically caused by the recession and reduced economic activity. The remainder is frictional unemployment, including individuals who voluntarily quit their jobs, and structural unemployment, including the disadvantaged who lack sufficient skills and the displaced who lost their jobs because of changing technology.

About 38 percent of the unemployed are under age 25. Teenagers represent 16.8 percent of the unemployed, and about half of the unemployed teenagers seek only part-time jobs.

The Last Major Recession (November 1973 - March 1975)

In the last major recession, employment bottomed out at 85.2 million in March, 1975. Within two years, employment increased to 90.8 million, representing 5.6 million jobs or an average increase of 234,000 jobs a month.

By May, 1981, employment had risen to over 101 million, an increase of 15.9 million jobs in a little over six years.

Jobs Needed In The Eighties (1983-1989)

To achieve high levels of employment in the 1980s, three problems have to be overcome.

First, the cyclical bulge in unemployment caused by the recession, which involves up to 5 million jobs, must be eliminated by economic recovery.

Second, jobs must be found for new entrants into the labor force. The increase in the labor force is expected to average about 1.6 percent for the 1980s - equal to 1.5 million to 1.8 million additional job seekers a year. This increase will not be as great as in the 1970s when the post-World War II baby boom swelled these numbers. However, it is obvious that sustained economic recovery will be needed to provide for the continually growing labor force.

Third, the structurally unemployed must be helped. The disadvantaged, most often young people who lack sufficient skills to become employed, must be offered training opportunities. More mature and skilled workers who have permanently lost jobs in declining industries may need counseling and retraining for new careers.

Overall, a better trained, highly motivated and self-disciplined labor force will be needed as the economy continues the shift from an industrial to a high technology base.

All told, some 16 million or more jobs will be needed in the next seven years. The statistics on the recovery from the 1974 recession indicate that such job creation is achievable. The major problem is to accomplish this goal through sound economic recovery and growth without increasing inflation or discouraging hiring by adding to labor costs.

The Wrong Solution

Unemployment always lags behind the business cycle and is highest when recovery has begun. In such periods, when pessimism is pervasive, costly proposals are often advanced, such as public programs to create jobs, mortgage subsidies, and health insurance for the unemployed.

These proposals always prove to be unnecessary since they never get fully started until recovery is going strong. Furthermore, such programs would increase the federal deficit at a time when it needs to be reduced. This would mean applying the wrong solutions, which would increase the deficit, abort the recovery, reinflate the economy and continue unacceptably high levels of unemployment.

Broad Action Needed

To assure high levels of employment in the 1980s, both economic recovery from the current recession and sustained economic growth are needed. Achieving these goals requires unwavering support of the following fundamental policy goals:

- Reduce both personal and business taxes to stimulate saving, investment, work effort, and productivity.

- Reduce the growth of federal spending and entitlement programs.

- Reduce the burden of federal regulations.

- Encourage a moderate and steady monetary policy.

- Enhance the ability of U.S. industry and agriculture to compete successfully in world markets.

Pursuit of these general goals will eliminate the cyclical bulge in unemployment and provide the jobs needed for new entrants into the workforce in the 1980s.

The statistics from the 1974 recession demonstrate that more than 200,000 jobs a month are created once economic recovery gets rolling. A favorable outlook is for up to five million more employed persons in the next two years, so long as the federal government acts to curb federal deficits and sustain the recovery. Such an outlook would mean a rapid abatement of the problems associated with health coverage for laid-off workers.

HEALTH INSURANCE AND THE UNEMPLOYED

Some Statistics

Of the 11.4 million persons unemployed in March, 1983, the breakdown is as follows:

- 6.8 million job losers, of whom 1.9 million were on lay-off expecting to be recalled and 4.9 million were job losers uncertain of being reemployed by the same employers.
- 900,000 individuals who quit their jobs.
- 2.4 million reentrants, actively seeking jobs.
- 1.2 million new entrants into the labor force, actively seeking jobs.

For the week ending March 19, 1983, figures show 4.4 million claimants receiving regular state unemployment compensation, plus another 1.4 million receiving other unemployment benefits, i.e., extended benefits and Federal Supplemental Compensation, railroad unemployment insurance, or benefits based on federal civilian and military service.

In March, 1983, the median duration of unemployment was 10.3 weeks. Those statistics mean that half had been out of work less than 10.3 weeks and half longer. However, because some individuals have been out of work for two years or more, the mean duration of unemployment was 19.1 weeks.

Current Options For Health Insurance For The Unemployed

Although the vast majority of Americans have access to health insurance through employer plans, it should not be overlooked that not all employers offer such insurance, and not all employees who are eligible avail themselves of it.

Those workers who lose their health insurance coverage when they lose or quit their jobs have various options. Virtually all employers provide some ~~limited~~ continuation of coverage of thirty days or more. Practices vary with such extensions of coverage because some plans are fully paid for by employers, some require employee contributions, and some include no employer contributions. Furthermore, most employer plans automatically provide for conversion of the insurance from group to individually paid-for coverage.

Those individuals whose insurance is terminated or who do not choose to continue it on an individual basis have several options. They may be able to secure coverage by the insurance of someone else in their family who is working. For example, one-half of unemployed married men have a working wife and three-quarters of unemployed married women have a working husband. Overall, two-thirds of those families with someone unemployed have someone in the family working. Therefore, there are various options for these unemployed people to be covered by the policy of the working family member.

Beyond this, and in the absence of any health insurance, the unemployed may purchase health insurance policies if they can afford to do so -- and such policies are cheap or expensive depending on whether they provide very limited or very comprehensive coverage for hospital and physician's expenses. In addition, medical expense coverage for accidents is available in various other forms of individual insurance such as auto insurance and homeowners policies.

Reentrants or new entrants to the labor force who are unemployed may already have some form of individually-purchased or family-purchased coverage or may be covered by the employer policy of a working spouse or parent.

We have no clear picture on how many persons have individual commercial, Blue Cross or fraternal plan health policies in addition to employer coverage. However, this type of coverage, if carried, is available to someone who becomes unemployed.

Those unemployeds who have no health insurance may be helped by other family members, friends or charitable organizations, and many physicians will respond to urgent needs with reduced-cost or free services.

Finally, there is the social safety net, i.e., Medicaid is available to the truly needy.

Therefore, is there a problem to be addressed with a major new entitlement program? We think not. Is there a problem that requires costly new federal mandates on group health policies? Again, we think not. Is there a problem? Yes, but it appears to be one that can be solved largely through existing private and state programs.

New Proposals

The Social Security Act Amendments of 1983 made it clear that states would not violate federal prohibitions against diverting unemployment trust funds if they permit unemployment claimants to buy health insurance with a portion of their weekly benefit checks. Therefore, there is no federal impediment to any state experimenting with some form of health coverage for individuals receiving unemployment compensation. However, this is a complex and difficult situation. For example, the cost of administering any such program should not be financed from Federal Unemployment Tax Act revenues, which currently are insufficient to pay for the existing responsibilities of the state unemployment offices. Expenditure of FUTA receipts for costs associated with a new health insurance program will further limit the ability of the U.S. Employment Service to fulfill its basic mission of finding jobs for the unemployed.

Various House and Senate bills would grant the states up to $5.4 billion over several years to provide health insurance for unemployed individuals and their dependents. As a cost-sharing feature, unemployment claimants who participate could be required to contribute up to 8% of their weekly unemployment checks for such coverage. All covered individuals may be required to pay 20 percent of the cost of care.

We oppose such measures for the following reasons. The magnitude of the federal budget deficit argues against additional spending. Moreover, these bills would create a new open-ended entitlement program at a time when Congress is grappling with efforts to regain control over existing entitlements. A subsidy would be offered to all unemployed individuals without regard to their means -- a new welfare program without a means test. Further, health coverage would be offered to those who already have such coverage or have access to it through a working spouse or other family member. Finally, in some cases, the availability of a government sponsored health insurance program could act as an additional disincentive to seeking employment.

Several bills would require that employers carry laid-off workers for three months or more, or contribute to a state pool. We oppose such measures because they would increase total labor costs and discourage employment. In fact, if an employer already had to lay off employees and then the government increased labor costs, the result would be further lay-offs -- a dangerous spiral. For the same reasons, we oppose limitations or elimination of the tax deduction for employer-paid health benefits if employers do not extend coverage for unemployed individuals or contribute to state pools.

Needless to say, the impact of such federal mandates would fall heaviest on small businesses. It is small business that is being hurt most by the mandating of employer health coverage for workers aged 65 to 69, Social Security tax increases, and the TEFRA pension changes. There is one simple way to avoid increased health costs imposed by the federal government -- terminate the health plan. We do not want to see small businesses abandon their pension or health insurance plans. This is one of the major reasons that we oppose the above proposals.

Conclusion

The foundation for an enduring economic recovery has been created in the past two years. Remarkable success has been achieved in reducing double digit inflation. Interest rates have fallen dramatically. Counterproductive government regulations have been better controlled. While more needs to be done in each of these areas, the progress to date has been substantial.

Economic recovery has started, and the benefits of such recovery are imminent. We do not support new entitlement programs that would increase federal deficits, hinder recovery and add unmanageable burdens to small business. The higher level of employment that lies ahead in the next several years is the best solution to the health insurance coverage problems of those currently unemployed.

In the meantime, there are a variety of private options available to unemployed workers to obtain health insurance. Where such options are not available, state programs such as pools and other short term approaches (as exist in 29 states currently) can be utilized. Finally, there is the Medicaid program for the long term unemployed. These options are clearly preferable to federal intervention that could evolve into open ended entitlement programs.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, D.C.

Mr. GOLDBECK. I am Willis Goldbeck from the Washington Business Group on Health. Lest you weren't already aware of it, it's rather obvious that the employers are not of a unanimous voice on this issue.

There certainly is a segment of the employer population that has a philosophical opposition to Government's role here. There are others who are concerned about return-to-work disincentives, or the incongruous nature of cutting medicare and medicaid while adding new programs. And there are others who would like to have problem world be resolved through a voluntary, charity-based approach.

We believe that whatever is required of employers should not create a disincentive for the growing number of voluntary and negotiated plans, and it certainly should not impose such a burden that the provisions of basic medical insurance will be reduced, be that for small employers, or that the unemployment figures themselves will be increased for larger employers.

Employers around the country, particularly the very large ones, have been deliberating this issue for the last couple of months. Our own survey of those employers, while not complete, suggests that the bulk of them would agree with the following general points on this issue:

First, that there ought to be and there can be supported an immediate access period to spousal coverage.

Second, there can be agreement that all employment-based medical insurance should include a conversion opportunity, but we shouldn't be naive about the value of that.

Third, the 90-day concept of the benefit-extension requirement is consistently the trend—not the norm, but the trend—in large plans and is quite acceptable. It does not impose too large a burden. Not even for small employers. There certainly is no smaller employer that appears before you than our own organization. not those we represent, but our own organization. Our own assessment is that even with seven employees you can handle the 90-day extension without it forcing you out of business or out of purchasing responsible health insurance.

Fourth, we would oppose nationally mandated pools. They raise all sorts of other issues that are far too complex to delineate but that clearly are beyond the purview of this kind of a unique circumstance.

Fifth, that we would support the minimum-benefit package approach in the Waxman bill. And I would want to underline the importance of this kind of a concept. This would be the first time since 1965 that this Nation came to grips with the fact that a problem does not, ipso facto, require the Government to provide everything to everyone uniformly, and that it is appropriate to address a crisis issue with a crisis approach, and that providing some benefits is better than providing no benefits.

We are concerned that Congress not provide an unnecessary incentive for inpatient utilization, which some of the provisions of the existing bills would do.

We are very supportive of the concept that is delineated in several of the approaches that would place a recognition and incentive for some prevention, particularly in maternal and child health.

We would oppose the concept of making employers responsible for unemployed parents of workers, unless they were already dependents in the typical IRS definition. That would be an expansion of this entire benefit concept way beyond the nature of what we are originally here to talk about.

Finally, I think it is important to note that all employers realize the price of any new plan will be high. Utilization in this period has been well documented to be greater than at any other time. That also increases an added upward pressure on experience-rated plans.

But it must also be recognized that employers are going to pay a high price for unemployment anyway. It is unavoidable, as the costs for uncompensated care are shifted to private payors.

The unemployed are in a new category in the United States, unlike the unemployed of any other period of our history. They need help, and those who are employers must do their share to provide it.

Senator DURENBERGER. Thank you very much.

Just for purposes of whatever questions or additional reactions we might get, I have to make it clear that we are talking about two things during the course of these hearings, I believe. One is what we do about currently unemployed persons—those who are eligible for unemploymen compensation benefits—and what we do in what might be called the "longer run," meaning from the day after we pass a bill on out, for people who at that point in time are in an employment setting. You can change the relationship between an employer and an employee in order to provide for that period when they might be unemployed.

The proposal which the chairman and I have made is intended in large part to deal with the current problem of those who are unemployed but eligible for unemployment compensation. It is only in part designed to affect the current employment system by suggesting the spousal option, or whatever we would call it. It does not get into the issue of continuation of benenits, the 90-day recommendation, or any of those sorts of things. And on that issue we certainly appreciate the testimony here.

Probably it would be helpful to us and for the record of this hearing to see what—maybe some of it is covered in your testimony, Mr. Goldbeck—what the record is of employers in this country at various levels of numbers of employees, again, starting to move toward continuity of one kind or another, so that we can see what the trends are, what the costs are, and so forth.

But let me just, for the purposes of one question, zero in on the condition of those who are currently unemployed, and find out what you see to be the problems in connection with a proposal which finances a minimum set of benefits at the State level—voluntary programs at the State level—where the premiums for the coverage can be paid for in large part out of unemployment compensation payments, and where the Federal role is principally to legally facilitate the utilization of the UC program, and so forth; but, more importantly, to recognize that in the fiscal disparities

that have been created between States in this country by the recession, and this particular recession which hits harder at certain industries than others which are in a long-term condition of unemployment, that we ought to play some role in trying to level off the resource base under those State programs.

That is the main function for the recommendation of using title XX financing. It is not to start a new program with a federally funded base; it is just to recognize the realities, the fiscal realities that undergird State and local government in this country, and that some States have the capacity with the help of cost sharing to meet this minimum objective, but others—the Michigans of this world that we keep hearing about—find it extremely difficult to do that, and that we contemplate a 2-year period of time to help these people. And if we can find a better program to help those people at the end of 2 years, we'll do that, at the same time as we address some of the issues that have been raised in terms of permanent help within the framework of continuity and some of these other programs.

Now, would each of you react to what's wrong with our temporary proposal? Is there a way we could do it better? Or is, as one of you gentlemen implied at least, there just not any problem out there? I mean there was a fellow out here who we heard from this morning who said that the best deal Blue Cross would offer him was $192 a month, and he's only making $190 a week on his unemployment comp. That's not a problem for that guy and his family. Now, if that's the case around the country, I wish you would tell me whether I'm wrong or he's wrong.

Can we start with you, Jan?

Mr. OZGA. Well, I think we recognize that there is a problem. The magnitude of the problem is debatable.

Second, lack of health insurance for the unemployed is clearly a byproduct of the employment problem. If you solve the employment problem, you solve that adverse byproduct.

We have also mentioned that there are existing private and State avenues available to provide health insurance for the unemployed.

You mentioned what are our problems with the particular proposal. First, there is Federal financing of that program. We are not sure where the money is going to come from. And, second, there are tax penalties imposed on the employers who don't comply with certain provisions of that bill. We have problems with that.

We see, as Mr. Goldbeck pointed out, a trend toward extension of benefits, conversion privileges, what have you. That is something that should be encouraged.

Mr. BLISS. We are simply not prepared to say that a Federal program is necessary at this time to meet the emergency situation.

With respect to those States that have severe problems it may be that some type of revenue-sharing should be allocated for that purpose. But we would agree to that approach only to the extent that this committee believes that such temporary relief is necessary, and to the extent to which it is a temporary program and not the beginning of a new Federal entitlement. History has taught us that very few Federal programs in fact are temporary. Once entitlements are begun they tend to have a life of their own. It is very

difficult to retreat from a program that has begun. People begin to have vested interests, and it develops a midlevel bureaucracy to argue for its perpetuation.

So there is a healthy skepticism about the temporary nature of any new initiative like this.

But to the extent that the committee feels that the problem must be addressed immediately, apart from seeking long-term solution in the private sector, to which our comments are primarily addressed, we would certainly wish to see it a temporary program. We would wish to see as much flexibility at the State level as possible. We would wish to see it utilize the private sector and the private insurance skills and market to the maximum extent possible. And we would like to see as little Federal involvement through regulations and standards setting and the mandated designs of plans as possible.

Senator DURENBERGER. Well, let me say I really understand all of that, and I appreciate it, particularly the comments about the entitlement, because I can recognize the reverse of that, which is that there is an ocean out there that fully paid health benefits pay people in health benefits rather than in cash. It is something that a lot of you gentlemen and your members have given us. Now you are unwilling to abandon it. You have your own bureaucracies, you have your own notions that you can't touch health insurance, "Put all the money in there and give them nickles and dimes in cash," and complain about the Government's impact on the health care system. So I understand what you are talking about.

Mr. Goldbeck?

Mr. GOLDBECK. I appreciate that lead-in. [Laughter.]

I think one of the things that we came to in our conclusions was that, first of all, the private sector is not equipped to handle short-term crisis intervention sorts of activities, just by its very nature.

Second, that you are absolutely correct, that what ought to take place from the Federal standpoint is to assist those areas that are in the greatest need.

Therefore, the kind of allocation system that you and a number of the others have suggested seems to be appropriate. Whether the exact formula is or not, I think remains to be seen. But certainly the conceptual approach is correct.

We have some trouble with the idea of tying this entire concept to medicare and medicaid levels of benefits. In many cases that would mean unemployed people were receiving far larger benefit packages than when they had been employed.

The benefit packages themselves are at a time when we know that medicare and medicaid are inherently flawed in many respects, and are beginning to undergo their first sort of serious re-evaluation and reassessments since the late 1960's. And that certainly should go on. Adding new categories to those programs that are having trouble hanging in there on their own doesn't seem like necessarily the best way to do it.

That is one of the reasons we felt you could maximize the Federal dollar involvement in the long run by coming to grips with the minimum benefit package approach.

We would like to see that there be a recognition that there is a need for a systemic approach involving the various sectors of the

society, presumably in the most responsible apportioned shares that one could come up with.

If indeed we are fortunate x number of years from now and there is no more unemployment problem in the United States, it becomes irrelevant whether this program is still on the books.

So I am not concerned that we solve the unemployment problems and are left lugging the burden of this program, because nobody will be using it if they are not unemployed. If, on the other hand, there is significant unemployment, there is still going to be a need for a program.

So addressing it from a more systems-oriented approach, with all the different sectors involved to one degree or another, seems to us to be the way to go about it, rather than having to reappear in another set of hearings on how to start it again every time there is a big flap. And I think that is an important consideration.

So it isn't so much that we think your approach is wrong, it's just that there are parts of yours that seem to be eminently reasonable, and there are some cautions and concerns about it that we think are somewhat addressed at least through the Waxman-type approach.

Senator DURENBERGER. Well, I am not here to defend mine; I am just here to try to find an answer, a short-term answer, for what we hope is a relatively short-term problem of the unemployed.

Let me say, when you start to respond, that we are particularly concerned for small business in this. I mean, we did hear from the mineworkers, and we know they are going to be off for a long time, but they have been protected for a long time, also. And there are a lot of other large companies that are doing things for people, at the cost of providing the kind of health care we have in this country.

But the cost of that health care for small businesses is becoming an incredible burden on small business. So, I wanted to add that kind of dimension to it.

Mr. OXFELD. Senator, I suggest that even a large company which is forced to lay off large numbers of its workers may not find themselves in a financial position where they can afford to continue fringe benefit coverage of any kind for its laid-off employees.

Senator DURENBERGER. Well, is there a special way in terms of the various recommendations that are being made to us today to recognize the problem of small business employers? Or is it just a matter of having to recognize the problem of the high cost of health care, and unless we can do something about that we aren't going to be able to design a continuity program or some other kind of program to help out unemployed persons?

Mr. GOLDBECK. I don't think you are going to find a nice tidy solution.

Mr. BLISS. Senator, perhaps one way to approach the issue that may be helpful is to distinguish between those who are temporarily unemployed and what you might call the structurally unemployed. This is an issue that we are beginning to face with more concern perhaps than ever before in our history, as the old businesses seem to be compressing and the new high technology businesses are coming on board for which there has to be a period of retraining and adjustment in the labor force.

With respect to the temporarily unemployed, it is our view that the solution rests in the private sector, and it rests through the extension of benefits. We believe even small businesses can afford the extension of benefits through say a 90-day period of unemployment, and that this solution can be found through the private sector and does not require a government program.

The question of structural unemployment is a more difficult issue, and it has to be considered in the context of other governmental entitlement programs such as medicaid. And where do you draw the line between medicaid and the medically needed and the structurally unemployed?

It seems to us appropriate for the committee to look at those programs in an entirely different context. We would agree that if there is a problem of the structurally unemployed that requires a Federal solution, then that problem should not be placed on the private sector through some kind of cross-subsidy; rather that problem should be addressed as a distinct and separate issue.

But with respect to the temporary problem, the groups of people who are unemployed and then reemployed, laid off, and rehired, we think that solution can be found through the private sector, and even small businesses can participate.

Senator DURENBERGER. And that the problem obviously is: Who falls in that structurally unemployed category? I would hate to see everybody on the 91st day of unemployment fall into a structurally unemployed category, because they obviously don't.

But I do look here at an industry that some people might claim to have problems of structural unemployment, the automobile industry. And I see that the United Auto Workers, when they are working, contribute zero dollars to their health insurance plan, but General Motors contributes $3,624 a year; whereas, the people who are sitting back here under the Federal employees health benefit plan and the Blue Cross low-option, they contribute $390 a year, and the Government contributes $1,150 a year, and they get $1,540 total worth of benefit, which is about half of what those United Auto Workers are getting with their structural problems.

The premium difference alone would give the GM auto workers, if they were at our level, $2,084 in other things they can do with their money. And I could go on and on to illustrate the fact that we ought to look somewhat realistically at the condition of our country today, in which there are certain industries that are in a difficult problem. There are certain young men like that who have very real problems, but back home in the shop—for those who are still working—they are forking out $3,624 a year worth of, you know, questionable dollars going into health benefits, while we are struggling here to find a solution for some of these other people.

I say that only to recognize that it is a difficult problem and to say that I appreciate the fact that all of you have taken the time to concern yourselves with the problem, and to suggest that those who represent the employment sector in this country can be helpful in trying to help us address the immediate problem and the long-range problem.

I would say in response to your comment what I said this morning: We try to focus this hearing on the narrow problem of the unemployed in terms of an immediate solution but that we will start

hearings ostensibly on the subject of medicaid this summer, and try to look at the Federal role and the State role in that whole problem of people who currently fall in the crack between employment or unemployment comp and everything else.

So we would like to make those distinctions, so we aren't designing those apples-and-oranges programs here.

I hope you understand that my problem and John Heinz' problem in going out there on the floor and defending a benefits package is that a whole lot of people think in terms of those $3,624 a year policies and health care coverages, because there are so many of them out there, and with no contribution from the employee.

The Chamber position last year, as I recall, took some great pride with the fact that 35 percent of the people employed in this country don't have to contribute to their insurance coverage. To me that's national health insurance, not something you want to crow about. But that is the standard against whatever we try to do here continually gets measured.

So if you wonder why some of us would like to help you all tip that down a little bit so that we do more logical things here when we come to fill the gaps, that's precisely why we get behind some of these programs.

Senator DURENBERGER. Senator Heinz, do you have anything you want to add?

Senator HEINZ. Well, Mr. Chairman, I regret I wasn't able to get back from the U.S. International Trade Commission for the beginning of this panel.

I have had an opportunity to briefly take a look at some of the synopses of the testimony, and I gather that this group, all three of you, are not in favor of any kind of legislation in this area. Or am I wrong?

Senator DURENBERGER. You are wrong, I would say. They have a variety of comments that go across the line on that.

Senator HEINZ. I gather the U.S. Chamber's position is that we do not need to enact any legislation. Is that right?

Mr. OZGA. That's correct.

Senator HEINZ. I apologize, and tell me, if Senator Durenberger has asked this question: What happens to the person whose unemployment compensation is exhausted, where the local hospital just can't deliver any more free care—they have got to pay their bills too. What is the answer when you have got a lot of those people?

Mr. OZGA. Well, as we referred to in some of our responses to Senator Dole, there are other avenues open.

I have never heard of a hospital or a doctor which refused to give care to a needy patient. In fact, we are very encouraged to see where the AMA has said that a large percentage of their members is now providing free care, including this short-term charity approach, and I think that says a lot about the character of the American way.

Senator HEINZ. Well, generally speaking that does work. That's how it has worked in most of the other recessions, because in most areas of the United States a recovery has come about rapidly enough that neither the doctors—and in this case, much more importantly than the doctors, the hospitals, who have to build their costs somewhere, that that system has generally worked.

But we have a rather unique situation, and certain parts of the country are in this respect more unique than others.

Where the recession has been abnormally long—we've never had one this long—and second, in certain areas of the country—I come from one of them, Pittsburgh, Pa.—there may be more mills that will open up, but it is highly unlikely that most of the ones that will eventually open up will open up this summer or even this fall. We may have to wait for a 7-million car year or an 8-million car year.

Or, since a lot of what we have there is tubular goods which we produce for the people who drill oil and gas, about a third of whom have gone broke in the last year, and since there is both a gas glut and an oil glut, it is not that the sheet and tube mills won't reopen; they will reopen, but it could very well be 2 years before they reopen, having been shut already for 1 or 2 years.

Mr. OZGA. As I recall, your proposal advocates taking part of the block grant money already available to the States and moving it into a category that would cover part of this problem. Is that correct?

Senator HEINZ. There are two proposals--Senator Dole's proposal, and Senator Specter's and mine, S. 811. The latter is in a sense a temporary bridging block grant to the State, yes.

Mr. OZGA. Well, to the extent that that could be done with existing block grant money, we would support that.

Senator HEINZ. I don't want to mislead you. It is not existing block grant money; it would be additionally appropriated block grant money; although what I would prefer to do would be to take some of the money out of the jobs bill that is going to be spent 3 or 4 years from now, if then, and use it upfront now and forget the latter part of the Tennessee-Tombigbee Waterway that may be involved there.

Yes?

Mr. GOLDBECK. I think there are at least aspects of this problem that are nonamenable to either wishing it would go away or waiting for it to go away, and that there are things that the private sector simply is not in a position to take on with great speed. There are systems kinds of changes that can be brought about that are responsible, that do not pose a particularly onerous burden on any one category of the society, and seek to ameliorate what are instances of a national or a societal problem. And it seems to me that that is an appropriate kind of thing for this committee and the Congress in general to be trying to address.

There are expenses connected with the unemployment problems and the absence of health insurance that these employers have to pay anyway.

When hospitals do take in that uncompensated case, let alone when they leave it at the gate, but when they take it in, they are not doing that in the classic charity sense of consuming the cost. The person who is still paying is consuming the cost due to a cost-shifting process that is entirely understandable, but it ought not to be confused with charity. And certainly a business is a principal cost-shiftee.

So when we say that we understand there will be some new costs, some of that cost is really a transfer from costs that are already being incurred right now.

Senator HEINZ. But some of that cost is going to fall on the membership of Mr. Ozga and Mr. Oxfeld, on their members, to the extent that they have employer-paid health insurance, and most of them do, I guess.

I guess I should be congratulating you rather than complaining, because what you are saying is that it's OK with the employers of this country for us to increase the equivalent of back-door payroll taxes in this country.

I never thought I would see the day when the chamber of commerce came down here to in effect advocate increases in payroll costs.

Mr. OZGA. Well, you haven't. I think I need to clarify something.

Senator HEINZ. Excuse me. I'll let you have a chance.

Obviously you are not here testifying for an increase in payroll taxes specifically, and I don't want you to misunderstand me, but what we are really saying is, inasmuch as your members do pay in many instances first dollar coverage of employee health insurance, and since the hospitals that get this money are essentially closed-end systems—they bill their costs somewhere—the net effect is that they are billing them to you, or to your members, and by the time the cost accountants in each company get through with it it becomes a very real additional cost of employment per employee and has the result of either decreasing employment or decreasing profitability or making investment less attractive, or all of those.

That's why I say you may not willingly be in the position that you are taking, but in effect what you are saying is, "We would rather have our employees pay higher payroll costs than have the Federal Government put in a little bit of help here." That is what you are saying, it seems to me.

Mr. OZGA. Well, I think I need to clarify a few points, because you and Senator Durenberger brought up the same issue.

When we were here last testifying, we didn't point with pride to the fact that 35 percent of the health care provided through employment is paid entirely by employers. We pointed this out as a matter of fact. We are proud that 95 percent of all Americans had some form of health care coverage.

The disparity that you mentioned—between people having full coverage and people out of work having to pay for it—is clearly recognizable and one that many of the business and health coalitions around the country are coming to grips with.

And coalitions enable labor and business to talk about the fact that together they have a stake in containing health care costs. They are doing just that—once again, a voluntary approach.

I think it is also important to recognize that the ability of employers to respond to the short-term problems of health care for the unemployed is related to the size of the employer.

I take issue with Mr. Goldbeck's statement about the ability of the employers to respond to short-term crises. If anything, I think he underestimates the ability of employers to do that.

Frankly, if you were to wait for even this program to go into effect, it would probably be some time before it actually happened, and part of this problem would be resolved.

I think that some of the proposals that are mentioned in yours and other bills could be done voluntarily, very shortly, and without federal intervention.

Senator HEINZ. If they could be, why haven't they been?

Mr. OZGA. Well, again, I guess it is a matter of recognition of the problem and the ability to do that by some employers. The trend is clearly there.

Senator HEINZ. Does the U.S. Chamber have a model program that they are taking around to employers, saying, first, "There is a problem," and second, "Here are some facts," and third, "Here is a way you might approach it"?

Mr. OZGA. Yes, we have. We have had it for the last 5 years, our health action program. It encourages the redesign of health care benefits, designed to provide health care access to employees.

Senator HEINZ. And how long after someone is laid off does that model plan last for?

Mr. OZGA. We leave that to the discretion of the employer.

Senator HEINZ. It could last for 24 hours? It could last for 30 days?

Mr. OZGA. Possibly.

Senator HEINZ. Well, what kind of a model is that? That's no model at all.

Mr. OZGA. It is a model that allows employers to respond to the problem within their resources.

Senator HEINZ. Of course. They are free to do that. But you have just made a statement which, if left unexamined, would imply that you have this very forward looking, progressive, thoughtful, carefully thought out model that is going to tell employers how to solve some of these problems. You don't even deal with the problem of postemployment health coverage. You don't deal with it.

Mr. OZGA. This model program also points out what you have already discussed, and that is——

Senator HEINZ. But the model is, as I understand it, is that you do nothing. That's the model in this area. The model is zero, zip.

Mr. OZGA. We encourage the development of these kinds of extension of benefits primarily because of the issue that you have raised, the potential for cost shifting. If employers don't do this voluntarily, people will fall on public doles. And that cost eventually will get passed back to employers anyway. This is a way of doing it more directly.

Senator HEINZ. I thank you very much. We appreciate all of you being here. Thank you.

[Mr. Goldbeck's prepared statement follows:]

Health Insurance for the Unemployed

A Statement by the

WASHINGTON BUSINESS GROUP ON HEALTH

to

Finance Committee of the US Senate

by

Willis B. Goldbeck

April 21, 1983

My name is Willis B. Goldbeck, President, Washington Business Group on Health. We are here today because the problem you are seeking solutions to is real; there is a legitimate role for federal goverment involvement; and many of America's leading employers recognize that they, too, must contribute to the solution.

As you would expect, our membership normally seeks neither an expansion of government nor mandated increases in the benefits provided to employees and their families. However, we do acknowledge that unemployment, with the resulting loss of medical insurance benefits, is a problem of national dimensions. As such, the responsibility must be opportioned among the various sectors of our society: Goverment must do its share to reduce any significant health crisis; the individuals involved will have to make painful personal resource allocation decisions thus sharing in the financing of any proposed remedy; charity on the part of medical care providers and special compensating community action programs are both necessary and, happily, becoming more prevalant. Finally, management and labor must do their share, not only as tax payers but also by the direct provision of benefits extended for a reasonable period to those who loose their jobs through no fault of their own.

We reached these conclusions based upon an anaylsis that determined:

1. No single sector of society can afford to assume responsibility for a total solution, thus a joint effort will be essential.

2. This is a problem which has no one to blame, only victims to help.

3. Society in general and the economic recovery inparticular will not be served by either ignoring the problem or by driving millions of former workers—and tax payers—into poverty to attain eligibility for existing public programs.

4. The problem is not a reflection of temporary economic doldrums but rather of the changing nature of work in America. Therefore, unlike past occassions when the issue has arisen, this time a national response is appropriate.

Attached as an appendix is a brief review of Trends In Extended Benefits which was initally presented in our January 24 testimony to the House Energy and Commerce Committee.

Senators Dole and Riegle and Representatives Waxman and Walgren and their co-sponsors all deserve credit for forcing this issue onto the public agenda and offering important proposals.

In reviewing these proposals, we tried first to clarify the goal, establish some basic principles and then assess which elements of the proposals would be most successful in meeting these criteria.

Goal: To assist those who have, or in the future may lose medical insurance as a result of umemployment.

Principles:

1. The program must be a joint public, private, and personal effort.

2. This unique program should not be a surrogate for national health insurance nor should it attempt to address all the other problems in health care financing and delivery.

3. States should be given maximum flexibility in program design and financing.

4. Federal financing should be seen as a catalyst for state and private sector program development.

5. There should be no pretence that this special program can provide replacement insurance protection. A new minimum benefit package should be offered.

6. That benefit package should have some emphasis upon prevention.

7. Requirements on employers should:
   A. not be a disincentive for the growing number of voluntarily extended benefits.

   B. not impose such a burdon that the provisions of basic medical insurance will be reduced (small employers) or that unemployment will be increased (large employers already in major economic difficulties.)

   C. recognize that many families now have two wage earners both of whom have access to private insurance benefits.

   D. not result in financing pools and programs in which the unemployed receive greater benefits then they had while working (which would be the case if Medicare or many Medicaid

programs became the "minimum" benefit.)

7. Financial assistance should be targetted 'o those hospitals which are providing an increasing amount of uncompensated care due to the unwillingness of other hospitals to accept those who have lost insurance due to unemployment.

Our members are currently responding to a survey that sought their views of each legislative proposal. All the results are not in but a review of the completed responses shows:

1. Agreement to provide an immediate access period to a spouse who has lost their own job.

2. Agreement that all employment-based medical insurance should include a conversion opportunity.

3. Acceptance of the 90 day benefits extension requirement as representative of a moderate approach which, while far from inexpensive for employers, is consistent with the trends in benefit extension.

4. Opposition to nationally mandated pools. If these were experience rated, like unemployment compensation, then the companies with the worst economic conditions would have to pay for the whole pool. Alternatively, if the pool is not experience rated, then those firms which never have lay-offs would be paying millions for a benefit that their workforce never receives.

5. Support for the minimum benefit approach in the Waxman bill. The importance of this proposal should not be overlooked. It is a bold statement which recognizes that the federal government has an appropriate role in crisis reduction but, that role does not necessarily extend to maintenance of the status quo or to providing a guarantee of cost-free care for every real or perceived need.

6. Concerns that Congress not provide an unnecessary incentive for inpatient utilization (such as denying coverage of drugs for chronic care patients unless they are hospitalized.)

7. Support for the prevention orientation of the maternal and child care proposal coverages.

CHANGING NATURE OF WORK IN AMERICA

On the surface, it sounds so reasonable and so simple: provide emergency legislation to give health insurance coverage to those who lose coverge due to loss of employment.

Below the surface lies a morass of rapidly changing demographics, emerging shifts in how we value work, trends in technology and education which are out of balance with the needs and skills of our workforce, and the harsh reality that there are good reasons for what we have come to call structural unemployment.

Like it or not, the nation is not facing a short term unemployment problem that is suited to emergency approaches. To further complicate matters, the overall matrix of economic problems, including the deficit, are forcing reduced funding to public health, Medicare and Medicaid. Thus the ethical dilema: do we create a new category of persons eligible for assistance at the very time we are cutting back for those already in dire need.

HOW WE ARE CHANGING: WHO WE ARE

The American worker is increasingly female or foreign, or both, and is getting old. While our total fertility rate has stayed below replacement level since 1976, immigration and longevity have been the keys to population growth. For every 4 persons who entered the labor force in the 1970s, only 3 will do so in the 1980s. One result of an aging workforce is a reduced pool of those able or willing to take low skill, night shift, or hazardous jobs. Another complication is the incompatibility of a youth-oriented educaiton system when it is the adult worker who needs education and training to be of value in tomorrow's job markets.

Between 1969-79 we consumed, but surely did not assimilate, 4.3 million immigrants. Our "melting pot" was swamped by a 815% increase in Asia immigration while the inflow from Europe decreased by 46%. Mexican immigration alone went up 92.8%. It is not just the nature of work but also the worker who is changing.

In the process of these and other changes, the family unit of a working father and a mother as homemaker has been transformed from a classic to a myth. Work in previous generations was unavoidable if one was to survive and the structure of work fit the family structure. Today, we see both structures in the midst of change.

HOW WE ARE CHANGING: THE VALUE OF WORK

We were trained to consume, to live for the next generation, to work in order to eat, to produce in order to win. Although from different political isms, Karl Marx and Adam Smith were allies in fostering work ethics that are increasingly meaningless for post-industrial societies. As a nation, there is no longer a necessary relationship between productive capacity and full

employment. We may need full employment for many other reasons, but not to produce the goods and services for either survival or growth.

The structure of work is changing to meet this new reality. Job-splitting, flexitime, permanent part-timers, compressed work weeks, and cafeteria plans are all related to the new prevalence of dual-earner families, few children, and strikingly different values being attached to work itself.

The shift from a manufacturing society to a post-industrial information society has been accompanied by other shifts:

- from replacement demand to maintenance demand
- from an emphasis on quantity to one on quality
- from fear-based incentives to self-realization and participatory management
- from the consumption ethic to one of ecological conservation

We have chronic un, and under, employment in part because we have so over-inflated the criteria for jobs that many who are indeed capable are not eligible. From all of this, we have a growing number of those whom Willis Harmon has called "the superfluous people", those not fortunate enough to be employed while existing in a society where the fact of employment is still deemed a prime indicator of successful participation and contribution to that society.

HOW WE ARE CHANGING: NEW VALUES, NEW BEHAVIOR

Waiting for our traditional industries to "recover" is no less a fantasy than waiting for ET to phone home. We're already in Naisbitt's "information society", Lumford's "bio-technic culture", and Robert Hutchins' "learning society". All these and many more are delivering the same message.

Public behavior is already reflecting these changes. Leisure time has never been more highly valued. Appropriate technology with its emphasis on decentralized production and doing more with less is in sync with America's new migration to unincorporated rural areas. The high tech of telecommunications is helping the entrepreneurial spirit converge with the "small is beautiful" value orientation.

Let me give an example to demonstrate the impact of the changing nature of work as contrasted with the traditional view of layoffs.

Everyone knows the auto industry is both a provider of very rich benefits and a source of large numbers of layoffs. At General Motors, workers with less than two years service get one month of extended benefits for every two months worked. Those between two and ten years receive between one and two years extended coverage. Currently, GM technically has laid off some

200,000 workers. However, 171,377 have been gone so long they have lost their recall rights. Of these, 71,540 have exceeded the period of their extended benefits. Many more will do so in the coming months.

Whether from the management or union perspective, one must ask if it would be good policy for the government to require a firm that has reduced its workforce by 200,000 to expend more funds for extended benefits. Every new financial obligation can only result in more layoffs or reduced compensation for those who remain employed.

Another example is a southeastern manufacturer which offers hourly workers with 3-10 years of service a one year extension, two years if beyond ten years of service.

HOURLY WORKERS

Year	Total	On Layoff
1980 (January)	22,122	642
1981	20,466	1,598
1982	16,165	4,682
1983	14,353	3,662

From this chart you can see a reduction of 7,769 yet only 3,662 now on layoff. The difference (4,107) represents those already "structurally" unemployed and thus beyond the responsiblity of their former employer.

Another example shows the growing severity of the problem. A midwest heavy equipment firm currently has 12,522 on layoff. They average 226 days on layoff. Of the total 10,378 still have employer provided extended health insurance coverage. However, 10,155 will lose that in 1983.

NOTE: — Data compiled January 23, 1983.

Apendix

TRENDS IN EXTENDED BENEFITS

YEARS OF SERVICE	EXTENSION OF BENEFITS				
	End of Month	End of Month Plus	6 Months	1 Year	2 Years
Less than 1 year	X	X	X		
Less than 2 years	X	X	X		
2-10 years			X	X	X
More than 10 years			X	X	X

This chart captures the primary categories of extended benefits in relation to duration of service. Many companies have no benefit extension; others have a set amount regardless of service and there are countless variations that defy placement on any chart that would remain comprehensible.

UTILIZATION

Not surprisingly, our companies report increased utilization of medical benefits during periods of layoff. And this does not count the increase in diseases and accidents that are directly attributed to unemployment itself. Elective surgery is a major area of increase.

INSURANCE

Nationwide is marketing a hospital/surgical benefit in 60 or 120 day policies specifically aimed at the recently unemployed. While not inexpensive, they are cosiderably less than a regular, non-group policy which, with a $250 deductible, would be approximately $1900 per year. For a typical 30 year old couple, the unemployed plans would cost (60-day) $56.60 (120 days) $113.00. Coverage is limited but would be a major asset in any medical crisis.

EMPLOYEE CONTRIBUTION

Many companies require laid-off workers to make some financial contribution to the insurance premium. There is a geat variation in this practice with duration of service, duration of layoff, and number of dependents among the determining factors.

COVERAGE COMPARABILITY

Some employers reduce the coverage for those on extended benefits. Again, the patterns are not conclusive. While some emphasize protection from catastrophic expenditures, others drop the major medical although continuing the basic hospital and surgical benefits. The trend is to keep the full coverage and drop dental.

"LOST" BENEFIT

The total number of persons laid off in recent years contain many who had been employed for so short a time they had never passed through the waiting period. Thus, they had no benefit to lose. Another category had benefits but not enough seniority to earn any benefit extension. Then there are all those who had benefits and varying degrees of extensions. All of which further shows the dangers of thinking of the unemployed as a single group with comparable circumstances.

SELF-PAY OPTIONS

Several companies reported that they offer those laid off the opportunity to by into the full group plan coverage. Acceptance runs from 12-33% of those eligible thus many must conclude that the price is too high, either in absolute terms or in relation to other demands on their shrinking resources.

NOTE — This information reflects the experience of a select group of very large firms. It is not typical of all businesses.

Some typical examples are:

COMPANY	SERVICE	BENEFIT EXTENSION
Tenneco		
Salaried	less 6 month	1 month
	6-12 months	6 months
	1 year	1year
Hourly	less than 4 years	6 months
	more than 5 years	1 year
Libbey-Owens-Ford		
Glass division		6 months
Motorola		1 year
Alcoa	less than 2 years	26 weeks
	2-20 years	2 years
	more than 20 years	full retirement level
Kodak		end of month plus 2 months
American Can	less than 10 years	6 months
	more than 10 years	23 months
Kroger		end of month plus 2 months
Bethlehem Steel	2-10 years	6 months
	more than 10 years	1 year
Boeing		60-90 days
Ford	less than 10 years	1 year
	more than 10 years	2 years
Goodyear		
Salaried	Less than 1 year	3 months
	1-2 years	6 months
	more than 2 years	2 years
Hourly	less than 2 years	3 months
	more than 2 years	2 years
Westinghouse	3 years	1 year
Armco	less than 2 years	1 month
	2-10 years	6 months
	more than 10 years	1 year
Kimberly-Clark		1 year

Senator HEINZ. Our next witnesses are a panel consisting of Dr. William Hirsch, Dr. Martin Wasserman, and Mr. Matthew Coffey.

Let me say I am very pleased that Dr. Hirsch, who is from Johnstown, Pa., chief of medicine and director of emergency services at Mercy Hospital, and the medical director for Operation Touch, is here on behalf of Operation Touch.

Dr. Hirsch, please be seated. Your reputation has preceded you here. Indeed, you were not only an enthusiastic invitee of mine but of some other members of the committee as well.

So we welcome you. Since your name appears first on our panel, please proceed.

STATEMENT OF WILLIAM HIRSCH, M.D., CHIEF OF MEDICINE AND DIRECTOR OF EMERGENCY SERVICES, MERCY HOSPITAL, JOHNSTOWN, PA., AND MEDICAL DIRECTOR FOR OPERATION TOUCH

Dr. HIRSCH. I thank you for the kind introduction.

I would just like to point out that I am a physician. I do practice medicine in Johnstown, Pa. Johnstown currently has the highest rate of unemployment in the country. Twenty-six percent of our work force is unemployed and a substantial number of people are underemployed in the area.

I guess we have a heritage of adversity; we have survived three floods and numerous other economic setbacks. Some of the national media have dubbed us "The Survivors," and I presume we will survive the present crisis.

These survivors once again have joined in a volunteer effort to alleviate some of the misery caused by the present day tragedy of high unemployment. Operation Touch was formed to coordinate a multifaceted volunteer program, providing assistance in the various areas of human needs. Initially, food banks, job counseling, retraining, clothing, and fuel bill assistance programs were established.

The private sector of medicine perceived a need for some form of assistance in meeting medical care needs. A group of physicians solicited and received unqualified support from a local hospital, Mercy Hospital. We then contacted Touch, and the concept of a medical care center was born.

We subsequently received help from other area hospitals, physicians were recruited, nurses, clerical volunteers, and I'm proud to say that within a week of the birth of the concept the Operation Touch Medical Care Center was in operation. We opened December 20, 1982.

It was somewhat difficult determining the criteria that we were going to use for eligibility, but a task force was formed and those criteria were established.

We have attempted to resolve the medical needs of the jobless, and at the same time we try to maintain an air of dignity.

I think you have to appreciate that most of the individuals that we are dealing with, unemployment is somewhat unfamiliar to them. They did not know how to use the system, much less how to abuse it.

We kept our screening procedures very simple, by design. What we were attempting to do was to fill the need of those people who were falling between the cracks: that is, those individuals not eligible for any other form of medical assistance, yet financially unable to pay for their own services.

When we interview these people we make a very special attempt to place them in a private office. Most of the area physicians gladly take those who are deemed eligible into their offices and provide care free of charge.

Those individuals who cannot be placed privately are then referred to the medical care center at the hospital. We do have scheduled hours twice a week, but anyone who has an urgent situation is advised to go to any of the area emergency rooms where care will be provided free of charge

We are basically geared for outpatient services for both acute and chronic illness. Basically, this includes physician evaluation, diagnostic procedures, and special therapeutic procedures where indicated, specialty referral, and supplies and drugs.

We have been able to accumulate a sampling of drugs from physicians and pharmaceutical representatives. The local pharamacists have agreed to a pricing formula that follows the existing State guidelines for medical-assistance patients. We established a fund for paying for the prescription bills. This fund was largely a contribution by the medical staff of the hospital, and although we devote most of our time to outpatient care, the patient who does require hospitalization is admitted, and thus far the hospital has been absorbing those expenses.

The cost of outpatient diagnostic workup, laboratory, X-rays, special therapeutic procedures, are also absorbed by the hospitals.

We have no geographic restrictions placed on our services. The center treats directly approximately 50 people a week, and I have evidence that at least twice this number are treated privately—probably many more.

To date we have performed at least 20-plus outpatient surgical procedures and have admitted a number of people for inpatient care.

I think other areas have taken up our idea. We get inquiries every week about how our operation works, and I am sure this has resulted in several programs of a similar nature being set up both in Pennsylvania and out of State.

We are well aware that these programs can provide some of the health care requirements of the needy, but not all of them. These are immediate, temporary, and stopgap measures, not a long-term solution. We feel we are meeting our goals, but volunteerism can only go part way.

The time, expertise, and efforts of individuals probably can be counted on in the foreseeable future; however, the cost of the items, of inpatient care, diagnostic procedures, drugs, supplies, therapeutics, cannot be borne indefinitely by the institutions. Either these costs will be shifted to the paying consumer in the form of increased insurance premiums or increased charges, or the needy will have to do without.

In the past year, 86,000 subscribers have been dropped from the rolls of Blue Cross in western Pennsylvania. I realize this may be

also shifted to other third-party payors, but I think this number is realistic and probably represents over a quarter of a million people who are without health insurance in this area at this time.

Many of these are proud individuals and will not seek medical help that they can't pay for. I think the thought of hospitalization frightens these people, realizing the resulting high cost.

Deferment of payment is not the answer. I don't think these people want to go back to work—if they get back to work—and have a mountain of bills to pay for.

The psychologic problems facing the unemployed are staggering, and I think only those of us who have a day to day acquaintance with these people can understand it fully.

Several years ago President Reagan charged us with the responsibility of volunteerism. I think the private sector of medicine has responded, at least in my area. We are willing to do our part, but we can't do it all. We need some help.

We cannot underwrite the costs that I previously alluded to for an increasing length of time. Without help the unemployed are probably going to be subjected to a level of care that is undesirable.

I think if one asks volunteers to dig a ditch, the least that they can expect is that the shovel would be provided for.

I am a native son of a steelworker. I worked in the steel mills for several years myself. I can empathize with the plight of the unemployed. I can relate to hard times, and I certainly can relate to the medical needs of the unemployed.

The ultimate answer is obviously getting the economy back on its feet. Locally, however, that is going to depend on the revitalization of both steel and coal. That solution is not imminent in our area, and help is needed now.

I strongly believe that the Federal Government has the capacity and the moral obligation to address this issue, and I urge you to give favorable consideration to some of the legislation before you.

Thank you.

Senator HEINZ. Dr. Hirsch, if Senator Durenberger will permit me, we have a vote on. He has just come back; I've got to go. Then there is going to be another vote right after that, so it may be superfluous by the time I get back here—let me just thank you once again for your testimony. I think it summarizes exactly the point of view that Senator Specter and myself, Senator Durenberger and others, have been trying to get across, not just to our colleagues in the White House but to the country.

To some of the panelists who appeared earlier before us, I think you sum it up like it is.

Thank you very much.

Dr. HIRSCH. Thank you.

[Dr. Hirsch's prepared statement follows:]

April 20, 1983

Senate Finance Committee Presentation

By

William P. Hirsch, M.D.

Chief of Medicine - Mercy Hospital of Johnstown, PA

Director of Emergency & Acute Care - Mercy Hospital of Johnstown, PA

Medical Director of "Operation Touch"

Gentlemen:

Johnstown, Pennsylvania has the highest unemployment rate in the country with 25.9% of the workforce unemployed and an equal or greater number who are underemployed. The area was devastated by a flood in 1977 and has not yet fully recovered. Our area has been recognized throughout the country as one that has such resiliency that we have been dubbed as "Survivors". These survivors have once again joined forces in a volunteer effort to alleviate some of the misery caused by the present day tragedy of high unemployment.

Operation Touch (Together Our Understanding Can Help) was formed to coordinate a multi-faceted volunteer program to provide assistance in the various aspects of human needs. Food banks, job counseling and retraining, clothing, and fuel bill assistance programs were initially established.

The private sector of medicine perceived a need for some form of assistance in meeting medical care needs. A group of physicians solicited and received the unqualified support of Mercy Hospital of Johnstown. Touch was contacted and the concept of a medical care center for the needy was born.

Subsequently, other area hospitals and physicians were recruited to make it a community-wide effort. Nurses and clerical volunteers were recruited and the health care center officially opened on December 20, 1982, within a week of the initial discussion of the concept. Unique as it may seem, traditional local competitive concerns were laid aside through the open and willing cooperation of individual physicians and institutional leaders.

Determining the criteria for patient eligibility in the program was not a simple task. Operation Touch, hospital, and medical representatives met with Department of Public Welfare officials, social service workers, area pharmacists, and others. It was imperative to achieve the goal of helping the jobless while at the same time having them retain their dignity in the process. To most of these individuals, unemployment was unfamiliar. They did not know how to use the "system" much less abuse it. Screening procedures were kept simple by design. The intent was to address the needs of "those falling between the cracks"; that is, those not eligible for any other form of medical assistance and not financially able to pay for medical services.

It was the consensus that screening procedures would be handled at Operation Touch headquarters; at a site other than the hospital. During the interview process, special emphasis was placed on having eligible patients treated in their private physicians' office. When informed of an individual's financial plight, most physicians have responded by seeing private patients in their offices free of charge. Those patients who meet the criteria for eligibility and who are not placed in a private office are referred to the Touch Medical Care Center located at Mercy Hospital.

Scheduled hours are held for elective visits two days a week, but patients requiring more urgent care can be treated at anytime by simply presenting themselves in the emergency room at Mercy Hospital of Johnstown, or at any other area hospital.

The "Center" is geared to provide basic outpatient services for both acute and chronic illness. This includes physician evaluation, diagnostic procedures, specialty referral and supply of drugs. Some sample drugs were collected from physicians and pharmaceutical representatives, and local pharmacists agreed to a pricing formula similar to that of the State's Medical Assistance Program. A fund was established for paying prescription bills. The fund was possible through a donation by the Medical Staff of Mercy Hospital. While the Center is devoted to outpatient care, including minor surgical procedures, when the need for inpatient care is established, the patient is hospitalized with the hospital absorbing the expenses. This is also the situation when outpatient diagnostic procedures, laboratory, x-ray services, etc. are required. Emergency dental care and replacement of eye glasses are provided at a reduced cost to the patient.

The Touch program has no geographic restrictions. The Center directly treats approximately 50 patients per week. Probably twice this number receive free medical care in private offices. Outpatient surgical procedures have been performed on approximately 20 patients, and there have been a number of patients admitted for inpatient care.

Since our program was founded, we have had numerous inquiries from other institutions and organizations in various areas requesting information on our program. As a result, many other similar programs both in

and out of state have recently been established. At least six hospitals of which we are aware in Western Pennsylvania have been in some way attempting to meet the health care needs of the unemployed.

We are aware these programs can provide some of the health care requirements of the needy, but certainly not all. These are immediate and temporary stop gap measures, not a long term solution. Although we are meeting our goals, volunteerism can go only so far. The time, expertise and effort of individuals probably can be counted on for the foreseeable future. However, the costly items of inpatient treatment, diagnostic procedures and drug costs cannot be borne by the institutions indefinitely. Either, these costs will be shifted to the "paying consumer" in the form of increased insurance premiums, and/or charges, or the needy will have to be denied these services. In the past year, 86,000 subscribers have been dropped from the roles of Blue Cross of Western Pennsylvania, representing over a quarter of a million people. Many of these are proud individuals who will not seek medical care even when it is offered free of charge. The thought ~~that~~ of hospitalization and the resulting high cost which is normally involved must bring fear to those who have no hospitalization insurance. The psychological problems facing the unemployed are staggering, and can only be fully appreciated when one has direct contact with those who find themselves in this terrible dilemma.

Several years ago, President Reagan charged us with the responsibility of "volunteerism". The private sector of medicine has responded. We are willing to do our part, but we need assistance. We cannot underwrite the costs previously alluded to for any length of time. Without help, the unemployed may be subjected to a less than desirable quality of health care. If one asks for volunteers to dig a ditch, the least that they can expect is to be provided with a shovel with which to accomplish this task.

Senator DURENBERGER. Dr. Wasserman, and then Mr. Coffey.

STATEMENT OF MARTIN WASSERMAN, M.D., DIRECTOR, ARLINGTON COUNTY DEPARTMENT OF HUMAN RESOURCES, ARLINGTON, VA.

Dr. WASSERMAN. Good afternoon.

I am Martin Wasserman, a physician, and director of the Department of Human Resources across the river in Arlington County, Va. Our department has responsibility for the county's public programs in health, mental health, social services, and other related human services programs. As part of our overall mission we help maintain and promote the public's health, well being, and self-sufficiency.

We see ourselves as the provider of last resort, offering services where appropriate alternatives do not exist. On occasion we act as a stimulus, a catalyst, if you will, with the private sector in order to further our objectives.

Today I have two issues I would like to bring to your attention: First, I would like to briefly describe our community's effort, Project Unite, that we are jointly sponsoring with the Arlington County Medical Society, where we provide voluntary health care services to individuals who have lost their medicaid benefits as a result of State and Federal policy decisions.

Second, I would like to point out, as others have before me, the limitation of voluntary programs such as our own in meeting the complex array of health services needs required by those 20 to 30 million Americans who have no other source of health care financing. This group includes the medically indigent who have always "fallen through the cracks" as well as the newly unemployed resulting from our country's current economic plight.

The concept of Project Unite, a public-private partnership between the County's Department of Human Resources and our local medical society, was developed over a year ago. Approximately 440 persons were identified by our agency who would lose their medicaid benefits if proposed State and Federal policy changes were implemented.

The Medical Society unanimously and excitedly embrace the notion of providing free in-the-office care to these persons.

Diagnostic laboratories and local pharmacies were contacted, who further expressed their interest. A network of service components were identified. Local hospitals also acknowledged their willingness to participate in this program. Over the next several months, after regulatory changes had been finalized, our division of social services identified specific individuals affected, and a health fair was set up to screen potential patients to gain baseline medical information.

Follow-up information was obtained, and patients are presently being "united" with Arlington County primary care physicians who practice in their neighborhoods. The willingness of our physicians to participate in this activity is laudable, and I am extremely proud to be a member of this Society.

Project Unite, however, for all of its praiseworthy intentions, does not pretend to be the solution to the problem of unmet health care needs in Arlington.

We have a large non-English speaking refugee population in fact, we are the most heavily impacted Indo-Chinese community in the United States, and every time I get a chance to come here I'll make that comment, and I've made it before, because we seek Federal aid in a number of different channels.

Senator DURENBERGER. Are you sure you're ahead of Ramsey County, Minn.?

Dr. WASSERMAN. Yes, we are. You are familiar with Arlington. [Laughter.]

Dr. WASSERMAN. Because of layoffs at Memco and Woolco and other employers, we will be facing an increasing number of unemployed, uninsured residents for whom Project Unite is not yet geared to deliver services at this time.

In addition, we have a number of transient males who have no source of local health care services. I believe we need to continue to work on developing a partnership approach—as Mr. Goldbeck cited earlier, a "systems approach"—in order to solve the unmet health care needs. In that partnership we need to unite government, health care providers, voluntary agencies, business, and labor. Perhaps Arlington's Project Unite could serve as a model in bringing together the public and private sectors and catalyze a national uniting effort.

This Tuesday I had the honor of being invited to a ceremony during which time President Reagan acknowledged the medical community's leadership role in providing volunteer services to the indigent. He was charming, eloquent, and sincere in his message.

Yesterday, while reading about this briefing in the newspaper, I became concerned that President Reagan's statements and those of Dr. William Rial, the current president of the American Medical Association, were misinterpreted by the press, which reported that our voluntary activity in Arlington, along with the activities that have been mentioned earlier today in 22 other programs, were successfully providing a solution, the sole solution, to the unmet health care needs in America. I heard neither the president of the United States nor the president of the American Medical Association make that statement. In fact, this White House briefing should underscore the need for additional efforts to be made with a broad partnership of actors including the medical profession as well as governmental agencies. A varied and complex number of components must be called into play in order to provide a full range of necessary health care services. This array includes:

1. Primary care and subspecialty medical providers,
2. Laboratory, radiographic, and other diagnostic technologies,
3. Emergency care facilities,
4. Inpatient hospital facilities—acute, chronic, and surgical,
5. Post-hospital rehabilitation programs and service
6. Medical devices and technologies,
7. Health promotion/illness prevention activities.

Although some of these services may be available in some places without cost through voluntary donations of time and energy, it

would be naive to believe that all of these services could be made available in every community at no cost to those in need.

Project Unite in Arlington demonstrates that the philanthropic spirit is a continuing and thriving force in American life today, but the current needs in our society exceed even this great effort.

And so, today, as one who has worked to mobilize a voluntary medical effort in one of America's communities, I urge you in the Senate to join with us and help shoulder this burden. I believe the Federal Government should assist us in forming a partnership to help meet the unmet health needs of these currently unprotected Americans.

Thank you.

Senator DURENBERGER. Thank you very much.

I appreciate your comments about both the President and the American Medical Association. Part of that was clarified this morning. I talked to Dave Stockman just a little while ago, and the other part has been clarified this afternoon. There will be an administration position on going beyond the voluntary effort to help the unemployed and it will be presented next Tuesday at this hearing.

Dr. WASSERMAN. I did not hear that message come across, and that was really my concern for being here. Those people who are part of that voluntary effort are saying, "We need some assistance; we need some help. And we don't want the Federal Government to rely solely upon the good intentions, and the limited good intentions—they need the shovels."

Senator DURENBERGER. Thank you.

Mr. Coffey.

ARLINGTON COUNTY, VIRGINIA
DEPARTMENT OF HUMAN RESOURCES
1800 NORTH EDISON STREET
ARLINGTON, VIRGINIA 22207

MARTIN P. WASSERMAN, M.D., J.D.
DIRECTOR

TESTIMONY BEFORE SENATE FINANCE COMMITTEE

Thursday, April 21, 1983

Martin P. Wasserman, M.D., J.D.

Good afternoon. I am Martin Wasserman, a physician, and Director of the Department of Human Resources in Arlington County, Virginia. Our Department has responsibility for the County's public programs in health, mental health, social service, and other related human services programs. As part of our overall mission, we help maintain and promote the public's health, well-being and self-sufficiency. We see ourselves as the "provider of last resort", offering services where appropriate alternatives do not exist. On occasion, we act as a stimulus, a catalyst, with the private sector in order to accomplish our objectives.

Today, I have two issues I would like to bring to your attention. First, I would like to briefly describe a community effort, Project Unite, that we are jointly sponsoring with the Arlington County Medical Society which will provide voluntary health care services to individuals who have lost Medicaid benefits as a result of state and federal policy decisions. Secondly, I would like to point out the limitation of voluntary programs such as our own in meeting the complex array of health care services required by those 20 - 30 million individuals who have no source of health care financing. This group includes the medically indigent who have always "fallen through the cracks" in our system as well as the newly unemployed resulting from our Country's current economic plight. The concept of Project Unite, a public-private partnership between the County's Department of Human Resources and local medical society, was developed over a year ago. Approximately 440 persons were identified who would lose their Medicaid benefits if proposed state and federal policy changes were implemented. The Medical Society unanimously and excitedly embraced the notion of providing free in-the-office care to these persons. Diagnostic laboratories and local pharmacies were contacted and expressed their interest. A network of service components were identified. Local hospitals also acknowledged their willingness to participate in this program. Over the next several months, after regulatory changes had been finalized, our Division of Social Services identified the specific individuals affected and a health fair was set up to screen potential patients to gain baseline medical information. Follow-up information was obtained and patients are presently being "united" with Arlington County primary care physicians who practice in their neighborhoods. The willingness of our physicians to participate in this activity is laudable and I am extremely proud to be a member of this Society.

Project Unite, however, for all its praiseworthy intentions, does not intend to be the solution to the problem of unmet health care needs in Arlington. We have a large non-English speaking refugee population (in fact we are the most heavily impacted Indo-Chinese community in the United States). Because of layoffs at Memco and Woolco, and other employers, we will be facing an increasing number of unemployed, uninsured residents for whom Project Unite is not geared to deliver services at this time. In addition, we have a number of transient males who have no source of local health care services. I believe we need to continue to work on developing a partnership approach in order to solve the unmet health care needs. In that partnership, we need to "unite" government, health care providers, voluntary agencies, business, and labor. Perhaps Arlington's Project Unite could serve as a model in bringing together the public and private sectors and catalyze a national uniting effort.

This Tuesday, I had the honor of being invited to a ceremony, during which time President Reagan acknowledged the medical community's leadership role in providing volunteer services to the indigent. He was charming, eloquent, and sincere in his message. Yesterday, while reading about this briefing in the newspaper, I became concerned that President Reagan's statements and those of Dr. William Rial, the President of the American Medical Association, were misinterpreted by the press which reported that our voluntary activity in Arlington along with 23 other similar voluntary programs were successfully providing the solution to the unmet health care needs in America. I heard neither the President of the United States nor the President of the American Medical Association make that statement. In fact, this White House briefing should underscore the need for additional efforts to be made with a broad partnership of actors including the medical profession as well as governmental agencies. A varied and complex number of components must be called into play in order to provide a full range of necessry health care services. This array includes:

-- primary care and sub-specialty medical providers
-- laboratory, radiographic and other diagnostic technologies
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-- inpatient hospital facilities (acute, chronic, surgical)
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-- medical devices and technologies
-- health promotion/illness prevention activities

Although some of these services may be available in some places without cost through voluntary donations of time and energy, it would be naive to believe that all of these services could be made available in every community at no cost to those in need. Project Unite in Arlington demonstrates that the philanthropic spirit is a continuing and thriving force in American life today, but the current needs in our society exceed even this great effort. And so today, as one who has worked to mobilize a voluntary medical effort in one of America's community's, I urge you, the Congress of the United States, to join with us and help shoulder this burden. Assist us in a partnership to help meet the health care needs of these people.

STATEMENT OF MATTHEW COFFEY, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF COUNTIES, WASHINGTON, D.C.

Mr. COFFEY. Good afternoon, Senator.

I want to submit my statement for the record and will just highlight a few things in it.

It is important to realize, on behalf of the county governments in the United States, that health care is certainly one of their substantial areas of expenditure. In 1980 counties spent over $22 million in health care which amounted to 36 percent of all county expenditures nationwide. It has an impact on general revenue sharing; it has an impact on all kinds of programs, and the counties are certainly one of the big players in this whole area of health care.

I have been asked to comment on the need as we see it from the county perspective. One of the indications of the need is that we are seeing an increasing number of county hospitals facing closure. We have seen it in Wayne County, Mich.; in Mobile County, Ala.; St. Louis County, Mo.; Chatham County, Ga.; Jefferson County, Ala. and others.

In the State of Michigan where unemployment has reached 17 percent, counties are seeing an unprecedented number of unemployed people who are medically indigent because they have lost benefits.

In Wayne County, the county hospital is seeing an increase in county-supported care and a decrease in revenue from health insurance. I think that's a clear indication of the problem we see facing us right now.

Hennepin County, Minn., has determined that the medically indigent population, those who don't qualify for medicaid but have no health insurance, has increased and is climbing. These people receive the majority of their medical care through county and State dollars.

Other county statistics point to sharp increases in eligible 18- to 21-year-olds in federally funded medical assistance only children's programs. The county suspects this is due to the high unemployment.

Finally, this county completed a survey of the effect of State and Federal cuts where people have lost their comprehensive health coverage. Thirty percent of the respondents stated they were deferring all medical care. And I think that's the point the doctor made earlier, that many Americans' pride causes them not to seek care any more.

In Mobile County, Ala., the university's general hospital has finally agreed to reopen its emergency room because the county guaranteed to supplement the $2.3 million it already pays to the hospital for indigent care under contract. Officials state that a 16.1-percent unemployment rate has forced the hospital to spend $20 million in indigent care during 1982. And that's just one county's experience.

In Texas, where unemployment is 10.5 percent, Harris County has seen a 12-percent increase in indigent outpatient care in 1982. County officials state that at least two-thirds of this increase is due directly to unemployment. Last year over $100 million of the county hospital's $150-million budget went to provide charity care.

In Oregon, where unemployment is over 10 percent, the State is considering expanding statewide a prepaid health program administered by Multnomah County that has provided care to the medically indigent in connection with the private sector.

Here the county has worked with Kaiser Permanente to administer a program called Project Health, very similar to the projects you have heard the two doctors comment on earlier The clients choose health plans from multiple options, and they share in the cost of health coverage on the basis of ability to pay and on the cost of the health plan selected.

The county and Project Health have seen tremendous increases in the demand for health care among those who have lost health benefits as the result of continuing high unemployment. The county can no longer continue its contribution of $4 million, and it is hopeful that the State will come in and help out with some of the costs that they are seeing.

In summary, our recommendations would be that NAC supports the use of mechanisms that are already in place, and the suspension of the State matching requirement which exists in the present medicaid program, especially since some 14 States presently require a local match.

We encourage the inclusion of a waiver authority that emphasizes alternatives to the traditional medicaid fee-for-service schedules. This would give States flexibility to develop, in concert with counties and other providers, benefit programs that encourage cost efficiency and competition through a choice of plans, prepaid or otherwise.

NACo will be happy to work with your staff to provide continuing assistance in the development of a sound program to provide relief to the millions without means to purchase health care.

That sums up my statement, Mr. Chairman. I will be happy to entertain any questions.

[Mr. Coffey's prepared statement follows:]

STATEMENT OF MATTHEW B. COFFEY, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF COUNTIES* (NACo), BEFORE THE SENATE COMMITTEE ON FINANCE.

I AM MATTHEW COFFEY, EXECUTIVE DIRECTOR OF THE NATIONAL ASSOCIATION OF COUNTIES (NACo).

NACo APPRECIATES THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO COMMENT ON PENDING LEGISLATION TO PROVIDE HEALTH CARE FOR THE UNEMPLOYED. WE COMMEND THIS COMMITTEE'S EFFORTS TO WORK OUT A SOLUTION TO THIS CRITICAL PROBLEM.

AS PROVIDERS, FINANCERS, PLANNERS AND PURCHASERS OF HEALTH CARE SERVICES, COUNTIES IN ONE WAY OR ANOTHER HAVE A ROLE IN ADDRESSING THE HEALTH CARE NEEDS OF VIRTUALLY ALL AMERICANS. OF THE 1900 PUBLIC HOSPITALS IN THIS COUNTRY, OVER 900 ARE COUNTY FACILITIES SERVING AS PROVIDERS OF LAST RESORT TO THE INDIGENT AND THE "NEW POOR" AMONG THE UNEMPLOYED WHO HAVE LOST THEIR HEALTH BENEFITS, BUT DO NOT QUALIFY FOR MEDICAID OR OTHER FORMS OF ASSISTANCE. WE ALL KNOW THAT THE NUMBER OF PEOPLE IN THIS SITUATION HAS GREATLY INCREASED AND IT IS NOW ESTIMATED THAT MORE THAN 21 MILLION WORKERS AND FAMILY MEMBERS WILL BE WITHOUT HEALTH INSURANCE COVERAGE SOMETIME DURING THIS YEAR.

COUNTY ROLE

NATIONWIDE, LOCAL TAX REVENUES SUPPORT THE PROVISION OF COUNTY HEALTH SERVICES FOR MANY OF THESE MILLIONS OF AMERICANS WHO HAVE NO

*THE NATIONAL ASSOCIATION OF COUNTIES IS THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN THE UNITED STATES. THROUGH ITS MEMBERSHIP, URBAN, SUBURBAN, AND RURAL COUNTIES JOIN TOGETHER TO BUILD EFFECTIVE, RESPONSIVE COUNTY GOVERNMENT. THE GOALS OF THE ORGANIZATION ARE TO: IMPROVE COUNTY GOVERNMENT; SERVE AS THE NATIONAL SPOKESMAN FOR COUNTY GOVERNMENT; ACT AS A LIAISON BETWEEN THE NATION'S COUNTIES AND OTHER LEVELS OF GOVERNMENT; ACHIEVE PUBLIC UNDERSTANDING OF THE ROLE OF COUNTIES IN THE FEDERAL SYSTEM.

HEALTH COVERAGE. IN 1980, COUNTIES SPENT OVER $22 BILLION ON HEALTH CARE, WHICH ACCOUNTED FOR 36 PERCENT OF ALL COUNTY EXPENDITURES NATIONWIDE. NINETY-EIGHT OF THE LARGEST PUBLIC HOSPITALS, 24 PERCENT WHICH ARE COUNTY-OWNED, PROVIDED A TOTAL OF $762 MILLION IN NON-MEDICAID CHARITY CARE IN 1980 ALONE.

NACo HAS SEEN AN INCREASE IN THE COUNTY-OWNED PUBLIC HOSPITALS WHO ARE STRUGGLING TO KEEP THEIR DOORS OPEN--COUNTY HOSPITALS IN WAYNE COUNTY, MICHIGAN; MOBILE COUNTY, ALABAMA; ST. LOUIS COUNTY, MISSOURI; CHATHAM COUNTY, GEORGIA; JEFFERSON COUNTY, ALABAMA; AND OTHERS.

IN THE STATE OF MICHIGAN WHERE UNEMPLOYMENT HAS REACHED 17 PERCENT, COUNTIES ARE SEEING AN UNPRECEDENTED NUMBER OF UNEMPLOYED PEOPLE WHO ARE MEDICALLY INDIGENT BECAUSE THEY HAVE LOST BENEFITS BUT DO NOT QUALIFY FOR PUBLIC ASSISTANCE. COUNTIES ARE ALSO SEEING LONG-TERM UNEMPLOYED WHO NOW QUALIFY FOR GENERAL ASSISTANCE AND MEDICAID BENEFITS BECAUSE THEY HAVE EXHAUSTED THEIR ASSETS.

IN WAYNE COUNTY, MICHIGAN, THE COUNTY HOSPITAL IS SEEING AN INCREASE IN COUNTY-SUPPORTED CARE AND A DECREASE IN REVENUES FROM HEALTH INSURANCE. THE HOSPITAL ADMINISTRATOR ESTIMATES THAT THE COUNTY'S PORTION OF THE HOSPITAL'S $60 MILLION BUDGET INCREASED FROM 15 PERCENT TO 20 PERCENT IN 1982 AND IS PROJECTED TO RISE TO 25 PERCENT IN 1983. THE NEED FOR ADDITIONAL COUNTY SUPPORT IS PRIMARILY RELATED TO THREE UNEMPLOYMENT-RELATED FACTORS:

- INCREASED NUMBER OF MEDICALLY INDIGENT UNDER THE MICHIGAN GENERAL COUNTY HOSPITALIZATION PROGRAM (JOINT STATE AND COUNTY SUPPORT);
- INCREASED GAP BETWEEN COSTS OF NEEDED CARE AND MEDICAID PROGRAM REIMBURSEMENT;

- INCREASED NUMBER OF MEDICALLY INDIGENT WHO AREN'T ELIGIBLE FOR ANY SPECIFIC PROGRAM.

WAYNE COUNTY ALSO NOTES THAT FURTHER ABSORPTION OF THESE COSTS IS IMPOSSIBLE; LOCAL GOVERNMENTS ARE IN AS DESPERATE FISCAL CONDITION AS THE INDIVIDUAL JOBLESS.

IN MOBILE COUNTY, ALABAMA THE UNIVERSITY'S GENERAL HOSPITAL HAS FINALLY AGREED TO REOPEN ITS EMERGENCY ROOM DOORS BECAUSE THE COUNTY GUARANTEED TO SUPPLEMENT THE $2.3 MILLION IT ALREADY PAYS TO THE HOSPITAL FOR INDIGENT CARE UNDER CONTRACT. OFFICIALS STATE THAT THE 16.1 PERCENT UNEMPLOYMENT RATE HAS FORCED THE HOSPITAL TO SPEND $20 MILLION IN INDIGENT CARE DURING 1982. INCREASINGLY, THIS HOSPITAL IS SEEING NON-INSURED PATIENTS REFERRED BY OTHER HOSPITALS OR DOCTORS, THE COUNTY WILL CONTINUALLY BE ASKED TO COMMIT LOCAL TAX REVENUES FOR THEIR CARE.

IN TEXAS WHERE UNEMPLOYMENT IS 10.5 PERCENT, HARRIS COUNTY HAS SEEN A 12 PERCENT INCREASE IN INDIGENT OUTPATIENT CARE IN 1982. COUNTY OFFICIALS STATE THAT AT LEAST TWO-THIRDS OF THIS INCREASE IS DUE DIRECTLY TO UNEMPLOYMENT. LAST YEAR OVER $100 MILLION OF THE COUNTY HOSPITAL'S $150 MILLION BUDGET WENT TO PROVIDE CHARITY CARE. HARRIS COUNTY HAS BEEN CONSIDERING DEVELOPMENT OF A PREPAID HEALTH PLAN FOR THIS GROUP OF UNCOVERED PEOPLE AND WOULD BE PLEASED TO USE MONIES GENERATED FROM PENDING LEGISLATION, TO BEGIN THIS TYPE OF PROGRAM.

IN OREGON, WHERE UNEMPLOYMENT IS OVER 10 PERCENT, THERE ARE PROPOSALS PENDING BEFORE THE STATE LEGISLATURE TO ADDRESS THE PRESSING PROBLEM OF HEALTH CARE BENEFITS FOR THE UNEMPLOYED, AND THE STATE IS CONSIDERING EXPANDING STATEWIDE, A PREPAID HEALTH PROGRAM ADMINISTERED BY MULTNOMAH COUNTY THAT HAS PROVIDED CARE TO THE "MEDICALLY INDIGENT." THE COUNTY, IN CONJUNCTION WITH THE PRIVATE SECTOR, INCLUDING KAISER PERMANENTE, RUNS A PROGRAM CALLED "PROJECT HEALTH" THAT LINKS THE COUNTY'S PUBLIC HEALTH CLINICS WITH PRIVATE SECTOR MEDICAL SPECIALISTS

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AND HOSPITALS. THIS PROGRAM, WHICH INCLUDES PRIVATE HEALTH PLANS CONTRACTING WITH THE COUNTY, PROVIDES COMPREHENSIVE HEALTH SERVICES TO MEDICALLY INDIGENT RESIDENTS WHO HAVE LOST HEALTH BENEFITS BUT DO NOT QUALIFY FOR MEDICAID.

CLIENTS CHOOSE HEALTH PLANS FROM MULTIPLE OPTIONS AND THEY SHARE IN THE COST OF HEALTH COVERAGE ON THE BASIS OF ABILITY TO PAY AND ON THE COST OF THE HEALTH PLAN SELECTED.

PROJECT HEALTH ATTEMPTS TO CONTAIN COSTS THROUGH ECONOMIC INCENTIVES AND COMPETITION WHILE PROVIDING BENEFITS TO MANY WHO WOULD OTHERWISE GO UNCOVERED. PARTICIPATING HEALTH PLANS COMPETE ON THE BASIS OF PRICE DUE TO THE FACT THAT THE ENROLLEE MUST PAY MORE FOR BETTER COVERAGE. THE PROJECT ALSO PRACTICES COST CONTAINMENT THROUGH PRE-PAYMENT BY EMPHASIZING ENROLLMENT INTO PRE-PAID HEALTH PLANS THAT RECEIVE A MONTHLY PREMIUM PAYMENT FOR EACH ENROLLEE.

THE COUNTY AND "PROJECT HEALTH" HAVE SEEN TREMENDOUS INCREASES IN THE DEMAND FOR HEALTH CARE AMONG THOSE WHO HAVE LOST HEALTH BENEFITS AS A RESULT OF CONTINUING HIGH UNEMPLOYMENT. THE COUNTY CAN NO LONGER AFFORD ITS CONTRIBUTION OF OVER FOUR MILLION DOLLARS TO THE PROJECT AND IS REGRETFULLY PHASING MUCH OF THE PROGRAM OUT, ALTHOUGH AS MENTIONED BEFORE, THE STATE HAS CONSIDERED EFFORTS TO CONTINUE AND EXPAND, STATEWIDE, THE PROJECT.

WE WILL BE GLAD TO SUBMIT FURTHER INFORMATION ON "PROJECT HEALTH" FOR THE RECORD AND TO PROVIDE YOU WITH ANY OTHER DETAILS YOU MAY NEED.

RECOMMENDATIONS

THE LEGISLATION AS INTRODUCED WOULD CHANNEL MONIES THROUGH THE EXISTING UNEMPLOYMENT INSURANCE AND MEDICAID SYSTEMS. NACo SUPPORTS

THE USE OF MECHANISMS THAT ARE ALREADY IN PLACE, AND THE SUSPENSION OF THE STATE MATCHING REQUIREMENT WHICH EXISTS IN THE PRESENT MEDICAID PROGRAM, ESPECIALLY SINCE SOME 14 STATES PRESENTLY REQUIRE A LOCAL MATCH.

WE WOULD ENCOURAGE THE INCLUSION OF A WAIVER AUTHORITY THAT WOULD EMPHASIZE ALTERNATIVES TO THE TRADITIONAL MEDICAID FEE-FOR-SERVICE SCHEDULES. THIS WOULD GIVE STATES FLEXIBILITY SO THAT THEY COULD DEVELOP, IN CONCERT WITH COUNTIES AND OTHER PROVIDERS, BENEFIT PROGRAMS THAT ENCOURAGE COST-EFFICIENCY AND COMPETITION THROUGH A CHOICE OF PLANS, PRE-PAID OR OTHERWISE. WHILE APPROACHES, SUCH AS WE HAVE DISCUSSED, MAY NOT BE FEASIBLE FOR STATES WHO DO NOT HAVE ALTERNATIVE RESOURCES AND MECHANISMS IN PLACE, IT IS NECESSARY TO ALLOW ROOM FOR CREATIVITY AND VARIATION IN MODELS FOR THE PROVISION OF INDIGENT CARE.

WE WOULD LIKE TO THANK YOU ONCE AGAIN FOR THE OPPORTUNITY TO COMMENT. NACo WILL BE HAPPY TO WORK WITH YOU AND YOUR STAFF TO PROVIDE CONTINUED ASSISTANCE IN THE DEVELOPMENT OF A SOUND PROGRAM TO PROVIDE RELIEF TO THE MILLIONS WITHOUT MEANS TO PURCHASE HEALTH CARE. WE WILL ALSO BE PLEASED TO CONTINUE TO PROVIDE INFORMATION OVER THE LIFE OF THE PROGRAM AS TO ITS IMPLEMENTATION AT THE LOCAL LEVEL WHERE THE HEALTH SERVICES ARE PROVIDED.

AT THIS POINT, I WILL BE GLAD TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator DURENBERGER. Thank you very much.

Let me ask a question first, of the doctors.

We had testimony earlier this afternoon, I think, that utilization of medical benefits increases during periods of layoff, and that elective surgery is a major reason for that increase.

Does your experience in providing care to the unemployed and their families confirm that particular view? And would you suggest that such increased utiilization is at all inappropriate?

Dr. HIRSCH. I will address that, Senator.

My experience has not been increased utilization during periods of high unemployment. With 26-percent unemployment in our area, I think we have some degree of background there.

But the people that we are seeing through the Operation Touch program, I think, is just the tip of the iceberg; I think many out there are just avoiding any type of medical service, even though it's free. Whether that is pride or what doesn't matter. I do not think that we have been seeing increased utilization of services.

Certainly our surgical experience—I am not a surgeon, but the people that we screen—we have had a very low rate of elective surgery on these people.

Senator DURENBERGER. I think the point that was being made was that if people know they are going to be unemployed for some period of time, and they have a health insurance plan that will run out somewhere in that point of time, that they quickly run in and use up all the services that they have sort of been bottling up over some period of time.

Dr. HIRSCH. Right. I would agree that that certainly happens. Understand, I am dealing with people who have already lost their benefits; so, my experience is a little different than what you are referring to.

I would think that is natural. If you are going to lose a benefit and you have something to be done, you are going to take advantage of that before you lose it.

If an elective surgical procedure were to become emergent, and you lost your coverage, it doesn't help you at that point in time.

Senator DURENBERGER. Do you have opinions, any or all of you, as we look at some kind of a program, about what should constitute a minimum benefits package in order to provide just basic coverage to people, but avoids the problem of being a big incentive not to find a job? Is there such a magic set of minimum benefits?

Dr. WASSERMAN. I'm not sure I can actually describe the whole package, but I think we certainly want to make sure that the catastrophic long-term illness protection is there that will prevent the anxiety and overwhelming medical-overload financing on an individual and in a family.

I am a public health physician, a pediatrician by formal training, and one of the things that frequently gets left out and is forgotten is the whole notion of preventive health programs whereby we can make some cost savings up front in making early identifications of illnesses and protect, eliminate, or prevent a recurrence or longer term chronic disabling diseases which are much more of a drain on the system.

I would urge you in your deliberations to look at the notion of preventive health care and to look at its long-range benefits.

Every time I go before our local board of supervisors and ask for funding for preventive programs, I am always asked to prove what the outcomes are in preventive health. It's very difficult, except in immunization programs and WICK programs where we are able to defend that notion. But I think an increasing number of people are becoming aware that it is going to really require a long-term outlook in order to identify how preventive programs help. We won't have the answers to those questions for another 30 or 40 years. But to underfund or to not consider funding those aspects is really kind of a short-sighted misguided goal.

Senator DURENBERGER. Mr. Coffey, let me ask you one question that deals with the proposal—I think it is 951, or whatever it is—that Senator Dole and I have put in.

We permit States to make arrangements with any provider in a State to provide benefits, so long as those providers are eligible to participate in the State's medicaid program.

Are you aware of any provider arrangements out there that should be permitted but would not be permitted under that kind of a mandate?

Mr. COFFEY. No, I'm not. We have seen variety of approaches across the country, but you want to try to encourage as much private involvement as you can. Try to get as many providers involved in this program as you can.

I don't see anything in the specific language that could be a problem yet. We will look at the legislation more specifically once we have had the opportunity to survey more of the counties regarding their concerns.

Senator DURENBERGER. Well, I think I am going to have to go over and do the second vote. I appreciate each of you being here and what you and the people you represent bring to this problem. I appreciate the time and effort that went into preparing your statements, and we probably will utilize your services. If we don't solicit them, you are free to donate them from time to time as we work on resolving this issue. Thank you very much.

Dr. HIRSCH. Thank you.

Dr. WASSERMAN. Thank you.

Mr. COFFEY. Thank you, Senator.

Senator DURENBERGER. The hearing is adjourned.

[Whereupon, at 2:57 p.m., the hearing was adjourned.]

HEALTH INSURANCE FOR THE UNEMPLOYED

WEDNESDAY, APRIL 27, 1983

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 1:35 p.m. in room SD-215, Dirksen Senate Office Building, Hon. Robert Dole (chairman) presiding.

Present: Senators Dole, Packwood, Chafee, Heinz, Durenberger, and Bradley.

The CHAIRMAN. I am pleased to be able to welcome Mr. Stockman who comes before us today at our request to share the position of the administration on how we might provide health benefits to those who are unemployed. We are grateful for his assistance and the willingness of the administration to address this important issue. They have committed a great deal of time over the last few weeks to examining various options, and come before us today with what I believe to be very useful information.

As I pointed out at the outset of our hearings last week, we are not certain that our proposal is the only option, and we are anxious to have suggestions on how we might change it.

Last week we heard from representatives of business, labor, county governments, and consumers. Their impressions were varied, and their recommendations mixed, all of which were very helpful to us.

Today's hearing will provide us a further opportunity to explore other possibilities. Our interest is in accommodating those with different opinions so we might reach some resolution on the problem before us.

As we heard last week, there are those who are not receiving needed care as a result of the loss of health care coverage. And while volunteer efforts on the part of physicians, hospitals, and others in the country are important, they are simply not enough.

So we are all interested in reaching some concensus on this issue that makes sense. And hearing the administration, I think, will be very helpful.

As we have indicated to the administration, there are a number of us on both sides of the aisle, Democrats and Republicans, who are trying to reach some responsible concensus on this issue. And, obviously, if the administration can be helpful as they have been, it will make our job easier, and, I think, much easier for the administration to find a provision or some provision they can accept.

Senator Heinz.

Senator HEINZ. Mr. Chairman, I thank you for being here, and I am delighted to see Dave Stockman here. We have had a number of conversations with him—Senator Specter, myself, yourself, and other Members of the Senate who are convinced that it is absolutely essential that the Federal Government be an active participant in addressing the needs of health care for those people who are going through this very lengthy recession, and who are finding it now not just difficult but nearly impossible, and in some cases totally impossible, to get health care.

It is my hope that the stories that have surfaced over the last 3 or 4 days that implied that the administration would not support any Federal money for health care for the unemployed, run contrary to some remarks the President made both to Senator Specter and myself in Pittsburgh and at the press conference he held in Pittsburgh. I also hope the administration will find a way to support emergency funding of health care for the unemployed through an appropriate means. Hopefully, that funding will be in the form of some kind of block grant to the States so that they have the maximum amount of flexibility in developing programs to meet their needs.

I think it is not inaccurate to say—and I note this particularly with Mr. Stockman being here—that our unemployed, without any health care whatsoever, are literally sinking faster than you did in the Atlantic.

I hope everyone will laugh at that joke. [Laughter.]

Senator HEINZ. But, unfortunately, I think the reason many people don't laugh is that those of us, like Senator Specter and myself who come from a State like Pennsylvania, and Senator Quayle from Indiana and others, realize that this is a deeply serious problem.

I would only add, Mr. Chairman, that when you held hearings on this last Thursday we did receive testimony that indicates quite clearly that there are numerous specific instances documenting the fact that people are literally being forced into untenable situations. Tom Samek, a coal miner from Green County, Pa., eloquently testified before this committee about what it's like when your wife gets pregnant before you lose your job; you lose your job; you lose your unemployment compensation; you lose your health insurance; and then you are stuck with a hospital bill for obstetrics and delivery in the delivery room. Exactly what happens to you in those circumstances?

Another, Pennsylvania, Dr. William Hirsch, who runs a free clinic for the unemployed up in Johnstown, testified as to what it's like when that clinic is stretched to the breaking point. No matter how hard they try, there's a limit to what they can do through volunteerism.

Mr. Chairman, I'm very pleased to see Mr. Stockman here. I hope he can help us address these problems, because it is a matter of great and grave urgency to us all.

The CHAIRMAN. Thank you, Senator Heinz.

We are pleased to also have with us today Senator Specter, the junior Senator from Pennsylvania.

STATEMENT OF HON. DAVID A. STOCKMAN, DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C.

The CHAIRMAN. Mr. Stockman.

Mr. STOCKMAN. Thank you very much, Mr. Chairman. I've submitted our statement, which was quite lengthy and detailed to the committee. It attempts both to analyze the kind of problem we are facing—it lays out a five point plan of recommended actions—and provides some of the justification for the steps that we have proposed.

I would suggest here that we submit that for the record, and that I take a few minutes to summarize what I think are the high points of the recommendations and conclusions of the administration.

The CHAIRMAN. It will be made a part of the record.

[The prepared statement of Mr. Stockman follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

Embargoed for Release
Upon Delivery
Expected 1:30PM

STATEMENT OF THE HONORABLE DAVID A. STOCKMAN
DIRECTOR, OFFICE OF MANAGEMENT & BUDGET
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

April 27, 1983

MR. CHAIRMAN:

Thank you for the opportunity to appear before your Committee today to discuss the problem of health insurance for the unemployed. As you well know, the Administration has made an systematic study of this issue over the past few weeks. I come before you today to share with you the conclusions the Administration has reached as a result of that study, and to outline the Administration's views of appropriate -- and inappropriate -- remedies to address it.

Summary of Recommendations

Our primary conclusion, Mr. Chairman, is that the problem of lack of health insurance among the unemployed is one of selective gaps and discontinuities -- and not a pervasive or general problem. As I will discuss in more detail shortly, the number of long-term unemployed who are wholly without access to health care services is really a limited subset of the unemployed. The Administration believes that the needs of this group can be met by a package of policy reforms such as the following:

--Requirements for employer insurance packages that ensure the unemployed access to continued coverage when they become unemployed.

--Requirements for employer insurance packages to ensure that the unemployed can be enrolled under a working spouse's health plan should they become unemployed and lose their own employer coverage,

--Amendments to the Social Services Block Grant Act to provide that funds available to the States can be used to fill in whatever gaps in coverage remain; and

--"Pay as you go" financing for any additional funding under title XX through enactment of the Administration's proposed limits on tax exclusion of employer insurance contributions at a level below that originally proposed.

Defining the Problem Carefully

Our support for these measures -- and our belief that these steps will be more than adequate to address health coverage problems among the unemployed -- is based on our study of the access of unemployed Americans to health care services. The general perception, Mr. Chairman, is that all unemployed American families somehow confront common problems due to the misfortune of unemployment. We have concluded, however, for the reasons discussed below, that lack of access to adequate health care is not a generic problem associated with unemployment, per se, and that in fact the great majority of the unemployed are not being denied care.

Continuation and Conversion Privileges

The truth is that many employers presently provide extended coverage to workers who are on layoff. In many cases, such coverage extensions are benefit plan features obtained as a result of collective bargaining. In other instances, employers offer coverages of this sort unilaterally. In any event, most insurance plans, enrolling workers as they do on a month-to-month basis, cover laid-off workers at least until the end of the month in which they are terminated. Such automatic extensions can provide up to four weeks of additional coverage even if there is no employer-financed extension. Many families use this remaining eligibility to actually obtain medical services family members may need.

Additionally, a number of States provide, as a matter of law, that workers may continue to enroll in a health insurance plan. In 12 States, employers are required to offer continued coverage to former employees at group insurance rates. In 11 States, employees must be offered the option of converting to individual health insurance plans. While these practices require laid-off workers to finance coverage out of their own resources, families with significant medical expenses at the time of termination are provided the means to limit their exposure without regard to pre-existing medical conditions. In most such instances, these features provide considerable protection.

Range of Unemployment Duration

Even in instances where employers do not continue health insurance for laid-off workers, several pieces of available data suggest that the problem is not as large as is commonly perceived.

The best available evidence is that even during economic recessions the labor force is a dynamic one and duration of spells of unemployment for most unemployed individuals remains relatively brief.

TABLE I

PERCENTAGE DISTRIBUTION OF UNEMPLOYMENT SPELLS

	Short (1-4 weeks)	Medium (5-26 weeks)	Long (27+ weeks)	Average
1982	41%	48%	11%	14.3
1978	49%	46%	5%	8.3

In 1982, the worst year for unemployment since World War II, the average spell of unemployment lasted just over three months. Although the average unemployment spell was much longer than it was during a non-recession year such as 1978, it was still the case in 1982 that two out of every five spells of unemployment lasted for less than one month.

Although many individuals experienced more than one spell of unemployment during 1982, the data still reveal that for most Americans unemployment is a temporary phenomenon. Long-term unemployment, which results in a severe strain on family resources, tends to be concentrated on a small but significant portion of Americans. But even during the most difficult economic times, such as last year, only 11 percent of all spells of unemployment lasted longer than six months.

Family Resources

Despite the vast array of social welfare programs, the family remains the primary social institution that cushions individuals from the financial hardship of unemployment. We often tend to view the unemployed, especially those with long durations of unemployment, as a homogeneous group in need of financial assistance. In fact, the family provides the main source of financial assistance for the unemployed. Although data for 1982 are not available yet, data for 1981 provide some indication of the financial resources of the unemployed in a recession year.

TABLE II

FAMILY INCOME OF THE UNEMPLOYED IN 1981

	Total	Duration of Unemployment:	
		Short-term (1-4 weeks)	Long-term (26+ weeks)
Average Family Income....	$20,898	$23,113	$17,035
Percent with Family Income Greater Than $20,000....	44%	51%	33%
Percent with Family Income Below Poverty.....	19%	14%	31%

As the data in the accompanying table indicate, the financial circumstances of the unemployed vary enormously. In 1981, for example, 44 percent of all unemployed individuals lived in families with incomes in excess of $20,000.

On the other hand, 31 percent of all individuals experiencing six months or more of unemployment lived in poverty, while over one-third of the long-term unemployed lived in families with incomes in excess of $20,000.

Of course, even families with substantial resources can experience cash flow difficulties that compel them to use their savings to tide them over spells where one family member is unemployed. But we should not conclude that such families will be unable to afford either health insurance coverage or actual medical expenses simply by reason or length of unemployment.

Coverage Through Working Spouses

The primary reason that family incomes remain relatively high among many of the unemployed is the presence of secondary earners in the household. In 1981, over 80 percent of the average family income among the unemployed represented earnings of family members. Although the 1981 data may not be representative of current conditions, the most recent statistics for the first quarter of 1983 indicate that the proportion of unemployed family members who have other family members working remains high. Among all unemployed individuals in families, 65% have other family members at work.

Besides providing an additional source of income, working family members are also a potential source of health insurance coverage for the unemployed. While data on family coverage among secondary workers is unavailable, many have held insurance coverage through their employer.

Some idea of the size of the non-covered unemployed population can be obtained by a close inspection of family characteristics among unemployed individuals:

TABLE III

CHARACTERISTICS OF THE UNEMPLOYED, 1983:I

Family Type	Millions of Individuals
1) Total Unemployed in Families	10.5
Intact Families	
2) Married Persons with Working Spouse	3.3
3) Dependents with Working Family Member	2.4
4) Sub-Total	5.7
Single-Parent Potential Medicaid Families	
5) Female-headed	2.1
6) Male-headed	0.6
7) Sub-Total	2.7
8) Unemployed Sole Wage Earners	2.1

As is indicated in the accompanying table, 10.5 million individuals living in families experienced some unemployment during the first quarter of 1983. Among the 5.2 million unemployed married persons, 3.3 million had working spouses. Unemployed husbands with working wives represented just over half of this group. Also, unemployed relatives in intact families with a working husband or wife numbered 2.4 million over the period. Therefore, of the 10.5 million unemployed individuals, 5.7 million lived in intact households with at least one parent employed, and hence were potentially eligible for coverage.

In addition, 2.7 million of the unemployed lived in single-parent potential Medicaid-eligible families. Subtracting both of these groups from the total yields a population of 2.1 million Americans who are unlikely to have a source of employer- or Medicaid-provided health insurance. This number represents a reasonable -- but lower-bound -- estimate of the totally uncovered population of unemployed family members.

One reason why this population represents the lower bound is obviously that, in certain instances, spouses may have elected to either accept self-only coverage, or may have elected family coverage through the spouse who became unemployed. As I will indicate later, however, this problem can be addressed without great difficulty.

Other Public Programs

We should also note that the total estimate of the unemployed includes many families that are eligible for public assistance, and who therefore qualify for and receive Medicaid coverage. In 22 states, two-parent families can be covered under Medicaid. In 30 states, families can be covered, even if they are not eligible for cash assistance, through "medically needy" programs, wherein high medical expenses are deducted from income to expand eligibility to those who are poor by reason of high medical expenses. While the Medicaid program does require an asset test, the value of the family's home and automobile is not counted for this purpose. In all, those longterm unemployed families most in need of assistance can receive it, in most instances, through existing public sector mechanisms.

Medicaid, of course, is not the sole effort directed at the health care needs of low-income families by the public sector. In the Administration's Fiscal Year 1984 budget, Mr. Chairman, over $85 billion is provided for health care services -- ranging from community health centers to immunization programs -- to provide health care to those who need it.

Private Sector Efforts

Our present health care system is characterized by voluntary private efforts to provide health care services to those who need it. There is strong evidence that those in the private sector have in fact expanded their efforts during the last few years to meet the needs of those who have become unemployed during the recession.

Private physicians have a long and commendable history of meeting the needs of those with limited resources. As the American Medical Association testified last Friday before the House Health Subcommittee, 70% of all American physicians provide reduced rates or free care services to those unable to afford care. A surprising 10% of all physicians are actually donating their time to special programs for unemployed workers and their families.

Hospitals have been and remain active. As the National Association of Counties has testified before your Committee, 98% of the Nation's largest hospitals provided over $750 million in uncompensated care in 1980. The evidence available to us suggests that this commitment to providing care regardless of compensation has if anything expanded markedly in the past few years. This sort of commitment, Mr. Chairman, goes far beyond explicit legal commitments, such as the charity care obligations under the Hill-Burton program, to provide free care. Rather, the Nation's community hospitals, which after all are established as private non-profit charitable instititutions, have maintained a long tradition of providing care without regard to the ability to pay.

Insurers and other third-party payors have also been active in meeting the needs of the unemployed. In six States, special insurance pools have been established to provide inexpensive coverage to the unemployed. And just last week, Blue Cross/Blue Shield of Western Pennsylvania announced a special program at heavily-discounted rates to unemployed workers and their families.

Coverage for physician services, for example, will cost only $8.50 per month for full family coverage. Coverage for hospital services will be provided at a 75% discount, both through low rates and by waiver of normal deductibles.

In all, the Administration believes that we must recognize the existence of these commendable efforts as we work to fashion solutions in this area.

AVOIDING LEGISLATIVE OVERKILL

As the foregoing has suggested, the problem of accessible and affordable health care services for unemployed workers and their families really consists of a number of special cases of individuals. Failure to recognize this fact in the development of legislation could prove a costly mistake. As you are aware, Mr. Chairman, the natural tendency of the bill-writing process is to expand consideration to an ever-wider scope of circumstances as special conditions and situational anomalies are brought to light. The danger is that the remedies fashioned to address these anomalies often result in adding in whole new classes of beneficiaries for a program despite the fact that only certain individuals within the stated class may have true needs that cannot be addressed some other way. As I will illustrate, Mr. Chairman, that danger is particularly present in the area of providing health insurance coverage to those who are presently uncovered.

The Dilemma of Equally Worthy Claims

The cause being considered by your Committee is the plight of those unemployed workers who previously had employer-financed health insurance, but lost it as a result of involuntary unemployment. Yet the problem of lack of health insurance coverage is not restricted to this group. There will be a strong temptation for legislative expansion as the circumstances of the target population are compared to the plight of:

--Unemployed families without prior coverage;

--Employed workers with no employer coverage;

--Low-income families with no recent work history who are ineligible for Medicaid; and

--Self-employed workers who receive no special tax breaks for health insurance.

As we learned long ago in the national health insurance debate, our society simply cannot afford to go all the way down this road. Yet if we move forward with an explicit Federal entitlement program in this area, we will be hard-pressed to explain why coverage should be bestowed on a narrow subset of the some 30 million Americans who are without health insurance.

The Minimum Benefits Problem

A complementary problem with attempting to address the needs of the unemployed through an explicit benefit program is the problem of establishing some minimum acceptable coverage package. On the one hand, the need to restrict costs would argue for some narrowly defined set of benefits -- perhaps restricted to so-called "catastrophic coverage", in which full coverage is provided only after the beneficiary meets some high deductible. Yet the very nature of such coverage would call into question whether any real benefit is in fact being conferred. To the extent that the unemployed have financial problems, the second $500 dollars of unaffordable expenses is just as insurmountable as the third. Attempting to draw the line in a way that is generally recognized as fair is probably impossible.

It is easy, however, to understand the fiscal stakes involved. Suppose the target population were restricted to 2 million families -- the rough number of families who have lost prior coverage that we estimate will still be on unemployment insurance on October 1. Extremely limited catastrophic coverage might cost perhaps $20 per month per family, or only $480 million annually. Yet present employer coverage plans with full benefits -- even at group rates -- can cost over $180 per month per family. Moving from the low end to the high end of coverage -- a normal tendency in these matters -- could raise costs nearly tenfold to nearly $4 billion annually.

The Prohibitive Cost of a New Entitlement

If we examine the potential for expansion due to these two factors, we are forced to conclude that any explicit Federal entitlement effort in this area would quickly escalate beyond affordable levels. Providing all eleven million unemployed workers with full family coverage at $180/month would cost an astonishing $19 billion annually. Even recognizing that many of the unemployed are single individuals and assuming a blended average cost of full coverage of $135 per month, the upside threat is in the $14 billion dollar range. The following table summarizes the potential cost range:

TABLE IV

COST OF COVERING VARIOUS GROUPS WITH HIGH AND LOW OPTION BENEFITS

Type of Benefit	UI Beneficiaries: With Prior Coverage	UI Beneficiaries: All	All Unemployed
	(dollars in billions)		
1) Number in eligible families(millions).....	(4.0)	(5.5)	(17.4)
2) Catastrophic with $1500 Deductible..... ($22.50/mo.)	$0.5	$0.6	$2.1
3) Catastrophic with $500 Deductible..... ($49.50/mo.)	$1.1	$1.3	$4.6
4) High Option Plan.... ($180/mo.)	$4.3	$5.8	$18.6

THE ACTUAL FISCAL THREAT IS UNKNOWABLE

I would caution, moreover, that the Federal government's track record in estimating the cost of new health care entitlements offers little solace as we go forward in this area.

Medicare

Shortly after the enactment of Medicare, the Social Security Trustees Report (1966) estimated that outlays from the HI and SMI trust funds would rise, in real terms, by 5.2% and 2.3% annually, respectively. In fact, the programs grew by 9.3% and 10.2% annually in real terms. As a result, an FY 1988 projection for SMI outlays would have been $5.6 billion under the original estimates; in fact, we now expect that SMI will hit $36.5 billion in FY 1988, a 548% overrun from the perspective of the original forecast. Similarly, the original estimate would assume, by 1990, HI outlays totalling $26.6 billion. The current forecast, however, is for HI outlays to hit $116.1 billion in 1990 -- a 366% overrun.

ESRD

Even short-run estimating in this area has been frought with guess-work. The 1973 Social Security Trustees report estimated ESRD costs for Fiscal Year 1974 -- a bare one year later -- at $65 million-dollars. Actual FY 1974 costs were in fact $90 million -- a 40% overrun one year out. At that time, the FY 1975 estimate was $84 million. In reality, FY 1975 spending hit $167 million --a 99% overrun two years out. Not surprisingly, spending in FY 1983 is now estimated at $1.4 billion -- a 2050% increase over the initial FY 1973 cost estimate.

Unknowable Behavioral Effects

The reasons for these overruns are the prodigious incentive effects built into the health care field.

On the beneficiary side, health care is considered such a superior good that consumption is limited only by income. Once a new entitlement is created obviating income limits, utilization of services climbs toward the sky.

On the provider side, the capacity for product upgrading and service improvement is constrained only by aggregate demand for health care services. Once an entitlement is created to fund whatever service consumption level is demanded, the "intensity" of service provided -- more doctors, nurses, supplies and machines -- is limited only by technological advance and labor supply constraints.

First Things First

I would hope, Mr.Chairman, that we have learned our lesson in this field -- that medical care entitlements strain the limits of the largest economy in the world. In fact, recent developments make clear to me that we are hard-pressed to afford the medical entitlements we now have on the books -- let alone being able to afford new ones. As recent studies from all directions have amply demonstrated, the HI trust fund is headed for bankruptcy at some point between 1987 and 1990. In order to stave off bankruptcy of this existing entitlement system, we will somehow have to contend with a projected $600 billion mismatch between income and outgo to the trust fund between now and the end of the century. This Committee knows well the magnitude of the task before us in either restraining benefits or raising revenues to fund this astronomical shortfall. Adding in new problems will only compound the difficulty of the task.

THE SOBERING FISCAL SITUATION

Even in the best of fiscal circumstances -- such as the halycon days of the late 1960's when the Federal government committed the projected "fiscal dividend" to many worthwhile purposes -- major new entitlement commitments should only be carefully undertaken. In the present environment, with projected deficits stuck permanently in the 5-6% of GNP range in the absence of concerted policy action, the creation of major new entitlement programs would be the height of fiscal irresponsibility. The following table summarizes our current plight in the entitlements area:

TABLE V

PRESENT ENTITLEMENTS COMMITMENTS

Category	1984	1985	1986	1987	1988	Total
	(CBO estimates in billions of dollars)					
Total Entitlements	394	418	444	477	511	2,244
SBC Proposed Savings	- 6	- 6	-11	-14	-17	-54
CBO Baseline Deficit	197	214	231	250	267	1,159

As the table shows, the Senate Budget Committee has, to date, been able to find only $54 billion in entitlement savings out of a $2.2 trillion spending base -- savings of only 2.4%. Of this amount, $19 billion has already been achieved as a result of the Social Security reform legislation created by your Committee. Another $10.7 billion consists of the savings achieved through adopting the Medicare prospective payment provisions as part of the Social Security bill. Apart from these savings, SBC can find additional savings totalling only 1.1%. As a result, under present Senate policy, total entitlement spending will rise by 28% over the next five years. In this environment, further expansions of the entitlements base would be unconscionable.

THE ADMINISTRATION'S VIEWS

For all of these reasons, the Administration would find any new Federal entitlement program in this area totally unacceptable. To meet the needs of those for whom unemployment is a barrier to care, the Administration would instead direct the attention of your Committee to a number of areas in which we believe constructive action can be taken.

Based on our analysis of the scope of the problem, the Administration concludes that there are three classes of unemployed individuals who are presently unable to obtain health insurance or needed health care services:

--Families where one spouse has lost coverage in which the family is unable to reenroll in the health plan of the other working spouse due to restrictive employer open enrollment practices;

--Families which would be able to afford to continue their present coverage or perhaps purchase a less costly plan, but are discouraged from doing so due to the difficulty of finding private market alternatives, or due to considerations of age or illness that make them poor risks; and

--A residual group of long-term unemployed who do not fall in either of the above classes who are ineligible for Medicaid, and unable to avail themselves of other public or private aid.

The Administration believes that the needs of these families can be met by a five-part plan based on the following three principles:

Support & Encourage Private Sector Initiatives

First, the Administration believes that much of the present hardship can be alleviated by constructive actions of the States and the private sector to meet the health care needs of the unemployed. Over the next few months, we plan to call attention to these efforts, and to encourage States and private institutions and individuals to emulate the many commendable efforts already underway. I would urge the Committee to undertake a similar effort, to determine ways in which we at the Federal level can be of assistance in promoting such efforts.

Augmenting Existing Private Insurance Coverage -- Providing Incentives for Increased Access

The Administration will also support efforts through legislation to ensure greater access among the unemployed to private insurance coverage.

Federal Support Tied Directly to New Financing

Third, the Administration will also support budget-neutral efforts to assist those for whom increased access and private sector and State assistance is deemed insufficient. If the Committee determines that increased resources are needed for this purpose, the Administration will support increased funding if and only if the Committee also provides a commensurate level of revenues, beyond those provided for in the President's budget proposals, to prevent increases in the deficit.

Legislative Changes

The specific legislative measures which the Administration would support are:

Mandated Coverage/Conversion Privileges

The Administration would support amendments to the Internal Revenue Code to mandate:

--Continuation of the present employer plan beyond termination, at individual rates at the expense of the former employee, for the lessor of one year or the period of unemployment; and

--An option for former employees to convert to a special low-cost "catastrophic" insurance plan, at market rates at the expense of the former employee, for the same period of eligibility.

The combined effect of these provisions would be to ensure unemployed workers access to a health insurance plan without disqualification for pre-existing conditions or other circumstances. By eliminating the need for the unemployed to seek and out find their own coverages, more families are likely to avail themselves of coverage.

Mandatory Open Enrollment Upon Termination of a Working Spouse

The Administration would also support legislation to ensure that individuals who lose insurance coverage at unemployment can be enrolled speedily in a plan available to their spouses. Specifically, the Administration would support:

--Permitting workers who had previously elected self-only coverage to elect full family coverage when a covered working spouse becomes unemployed; and

--Permitting workers who had previously elected not to accept coverage in favor of enrollment in a working spouse's plan to elect full family coverage should that spouse become unemployed.

As noted earlier, 40% of the unemployed have working spouses. While precise estimates are unavailable, we believe that the combined effect of these provisions will ensure coverage for a significant share -- perhaps as many as one-third -- of the unemployed.

State Assistance Through the Social Services Block Grant

The Administration would also support amendments to Title XX of the Social Security Act to make State provisions for health insurance for the unemployed an eligible activity under the Social Services Block Grant. In doing so, the Administration believes that the broadest possible latitude should be granted to the States to establish eligibility, benefit and delivery mechanism provisions. In that way, States will be able to use the funds available to them to assist those who are uniquely in need of help within their own States.

If the Committee agrees with this recommendation, and wishes to provide added financial resources under that title to the States for this purpose, the Administration could support such increased funding only if additional revenue measures are enacted to finance whatever incremental increase the Committee finds appropriate. Specifically, the Administration would support simultaneous enactment of the Administration's proposed cap on the exclusion of employer contributions from Adjusted Gross Income as an acceptable method of financing. Any funding increase under title XX, however, would have to be matched with a corresponding decrease in the level of the monthly exclusion cap below the level -- $175/month for family coverage -- that the Administration has proposed.

For example, enacting the cap in 1984 at the $160/month level would increase revenues in calendar year 1984 by approximately $500 million above the level assumed in the President's budget.

The Department of Treasury staff stands ready to provide technical assistance to the Committee as it considers these recommendations.

Knowing the Committe's desire to move forward expeditiously in this area, the Administration does not propose that you delay your proceedings further while we prepare draft legislation. Rather, we would welcome the opportunity to work together with the Committee to produce legislation within the scope I have just outlined. We are hopeful, Mr. Chairman, that any legislation developed by this Congress to address the health care needs of the unemployed could be fashioned in a manner that the President could accept. I look forward to working with you and your Committee toward achieving that end, and would welcome any questions that the Committee might have.

Mr. STOCKMAN. Well, Mr. Chairman, the major conclusion of the 3 or 4 week exercise that we have gone through to analyze this problem is that the lack of access to health insurance or affordable health care for the unemployed is not a systematic or generic condition among the unemployed, but at the same time, as Senator Heinz, Senator Specter, and you and others have indicated, there are serious hardships which do exist among selective groups of the unemployed. And those hardships and needs warrant a response by the Federal Government.

And the second conclusion that we have reached is that lack of ready, availability of coverage to many of the unemployed is probably a greater problem than affordability of protection. And that this committee—and we would be happy to work with you—needs to consider some very important but yet not overly difficult or costly steps to remedy that problem of availability.

We would, therefore, recommend that the committee avoid a sweeping generic solution. That is, a uniform medical entitlement for the unemployed, and pursue instead a multipronged strategy that carefully addresses the hydrogenous problems that actually exist for segments of the unemployed that we can identify and seek to assist.

In doing that, we would suggest that the first element of a solution should be broadened family health protection to mandatory open enrollment for working spouses. By our reckoning, 3.3 million or nearly 30 percent of those who experienced unemployment during the recession peak first quarter of 1983—hopefully the worst of the recession peak unemployment—had working spouses. And another 2.4 million of those who experienced unemployment during the first quarter were dependents who lived in intact households or families with one or more other working members, employed members, of the work force.

Thus, overall, 5.7 million or nearly 50 percent of all of those who experienced unemployment in the first quarter of this year were in multiworker families with a high probability of employer coverage available to at least one member of that family still employed, on the job, in the work force.

And so, therefore, we suggest that by mandating open enrollment so that the entire family can be protected by the policy of the remaining working or employed member, a significant proportion of the financial and health threat to the temporarily unemployed can be alleviated. And we strongly recommend that the committee amend the Tax Act to include that open enrollment for working spouses as a condition of tax excludability and deduction.

The second element of our recommendation concerns broadened access to continuation coverages for those who are laid off for temporary or longer spells. Here, as we pursued the study and analysis of this, we found a rather anomalous juxtaposition of fact.

On the one hand, significant proportions of the unemployed have both short spells of unemployment and/or relatively high income. In 1981, for instance, 44 percent of the unemployed had family incomes in excess of $20,000 per year, and the average family income was $20,500 for unemployed married men, breadwinners, and $24,150 for unemployed married women.

Second, the average spell of unemployment in 1982, a high unemployment rate of clearly a recession year—the average spell of unemployment lasted only 14.3 weeks, and 41 percent of unemployment spells lasted less than 4 weeks. So from both vantage points, the problem among this segment—and I am not here suggesting this is true for everyone—but among this segment of the unemployed, that is those with relatively high incomes or short spells, is not income or affordability, but availability of adequate temporary health insurance coverage.

On the other hand, I would suggest to the committee the underlying dynamic and structure of our national health insurance system, which is preponderantly work place based and group plan rated, works a needless injustice in the case of this segment of the unemployed, a substantial segment, with relative affordability or income available.

The families with income and incentive to buy temporary coverage find it difficult to obtain due to the high cost of individual plan retailing or due to disqualifications for preexisting medical conditions or due to the fact that adverse risk premiums apparently are built heavily into the individual plans marketed outside the mainline group insurance employer based system that we have in this country.

Therefore, we suggest that this mismatch of relative ability to pay among this segment of the unemployed and relative unavailability of reasonably priced temporary coverage be alleviated with two continuity of benefit mandates.

The first would be the right to purchase the existing employer plan for up to 12 months after termination or until reemployment.

And the second mandate would be the right to purchase from the employer's carrier by the terminated employee or laid-off worker a low-cost catastrophic-type plan at the employee's option that would have a much lower premium and a fairly high deductible of cost exposure.

Now let me stress to the committee that this would involve neither a Federal subsidy or an employer cost burden, but it would permit the temporarily unemployed who have the means and who have the available income to buy into the mainstream system of relatively cheaper employer based, work place based coverage, rather than having to go out into the other segment of our dual health insurance system and buy these excessively, exceedingly high cost individually rated plans with their high retailing costs, and their relative inadequacy of coverage.

Third, and finally, we recognize that not all of the unemployed are members of households with other workers, and, therefore, addressed in the first recommendation. And that a segment of the unemployed consists of those who face serious hardship due to long or multiple spells of unemployment or due to exhaustion of their UI benefits or due to the just plain fact of having already exhausted their family resources, income and assets. Here we recommend two steps to the committee. First that you open title 20 of the social services block grant so that it could be used for providing health benefits to the unemployed under a system of standards and eligibilities established at broad State discretion.

I believe it would be terribly time consuming and not productive for the committee to try to define specifically and in finite detail eligibilities, length of coverage, disqualification periods, types of benefit structure, deductibles, copayments and so forth, but rather in the form of a broad block grant through title 20. This job would be delegated to the States.

And the second step would be pay as you go financing in the form of a tighter tax cap on the excludeability of health benefits. And we estimate that $160 per month per family tax cap would generate $500 million a year more than is provided in the administration's recommended budget for 1984.

Let me conclude, Mr. Chairman, by stressing two important aspects of our recommendation. First, the administration strongly opposes—indeed, we cannot accept in any way a new entitlement, especially a nonmeans tested entitlement for potentially broad segments of the middle class. I would point out to the committee that under current law with the existing entitlements that we now have on the books ranging from social security to railroad retirement to food stamps—under existing law the costs over 1984 to 1988 are estimated at $2.2 trillion built in. And beyond the savings already enacted in the social security bill, the Senate Budget Committee in its 5-year budget plan that will be coming to the Senate floor shortly found it possible to recommend only $24 billion in savings over that 5-year period or 1 percent of the built in cost of the current vast array of entitlements that we have.

Now with 99 percent of that cost built in, unavoidable in the judgment of the Senate Budget Committee, and with $200 billion or greater annual deficits, it's not possible or conceivable for us to think about a new entitlement, especially when there are better ways on a more targeted basis to approach this problem as recommended to the committee.

I would also point out that given the sky-rocketing cost of the two medical entitlements that we already have for two deserving classes of Americans—the retired and the elderly in the form of medicare, and the poor in the form of medicaid—even the largest and richest economy in the world cannot afford a third long-run permanent exposure.

I remind this committee that soon you will be grappling with the unfunded problem of medicare, and with estimates which suggest that between now and the end of the century there will be a shortfall of more than $600 billion just to make that program solvent and pay for the entitlements that we now have in place.

Second observation I would conclude with, Mr. Chairman, is that for all practical purposes, the Federal Government today is insolvent financially with built in expenditures exceeding current law revenues by $1 trillion over the next 5 years. I would stress very strongly to the committee that any new money you put into the form of the block grant that we have recommended or some other approach—that any new money for any new programs, no matter how meritorious, must be tax financed in the same bill that creates the new expenditure. And that is why we have recommended linking any additional funding for title 20 to meet the needs of those with hardship requirements. That that additional funding, whatever the committee chooses, be matched dollar for dollar on a pay

as you go basis with a tighter tax cap to generate the revenue to pay for it.

That concludes my overview, Mr. Chairman. I will be very happy to take your questions, and questions from members of the committee.

The CHAIRMAN. Thank you very much, Mr. Stockman. I will follow the early bird rule. Senator Durenberger, Senator Heinz, Senator Bradley and Senator Packwood arrived after the chairman. And then I will have to depart at about 2 o'clock because we have a bankruptcy bill on the floor.

Let me say generally that I don't quarrel with anything in your statement as far as the pay as you go implication. And it does seem to me we just left a conference, a Republican conference, on the budget. And believe me we have serious problems, which you know better probably than we know. And we are not looking for new entitlement programs. We are not looking for additional ways to spend money without some way to pay for the activity.

You have indicated that one way to do it would be with the so-called tax cap to finance any new title 20 program activities. Now that isn't the only—in other words, if we found some other suitable ways, you would have no objection to that, as I understand it.

Mr. STOCKMAN. Well, that would be correct, Mr. Chairman We have suggested the tax cap because they are both health measures. And it would seem the most logical and appropriate linkage to make. But the more important principle is pay as you go financing. I would agree.

The CHAIRMAN. Now if we did reach some agreement with reference to a tax cap, you know medical costs vary between urban and rural areas and from region to region. Is there some way we could adjust the cap to take care of the cost variance in different areas? I assume that could be done, and we could work on that. We could reflect regional and urban and rural differences and medical care costs, I assume, in that formula somehow.

Mr. STOCKMAN. Well, Mr. Chairman, I think that is something that could be looked at. It might complicate what you are trying to do, but on the other hand those differentials exist. I think data bases exist for making different measurements in the regional CPI indexes so that is something that could be looked at, but it's not without some problems of its own.

The CHAIRMAN. No, I understand it might complicate it.

Are we going to increase the cost? If we start mandating coverage, we are going to increase the cost for other employees and the employers as far as insurance costs are concerned.

Mr. STOCKMAN. Well, of the three recommendations only one could have that potential impact. Clearly, the block grant for the hardship situations is a taxpayer financed program. Clearly, the continuation of coverage provisions that we have recommended would be financed by the employee, but we are trying to make it easy for him to buy into the mainline group health insurance system. I don't believe it could be demonstrated that there would be a significant cost subsidy or cost to the employer involved.

In the case of open enrollment mandated for working spouses, there would be some cost spreading through the system as a result of that. But on the other hand, employers today who employ people

with two members of the labor force are gaining some benefit on the cost side if only one rather than both of the policies are used. So there would be some cost impact there. I think it needs to be looked at carefully, but I do not believe it would be burdensome and enormous as would some proposals around simply to mandate 6 months of coverage at the employer's expense for anybody who is laid off or terminated. Then you are talking multibillions of dollars. And then you have some very serious policy problems.

I don't believe in our recommendations that we get into that kind of difficulty.

The CHAIRMAN. You've also suggested that employers be required to offer low cost catastrophic plans to the unemployed workers. Do you have any parameters? And do you have any suggestions on what the plan would provide?

Mr. STOCKMAN. Well, Mr. Chairman, I think we would like to work the details of that out with the committee, but what we had in mind was that in many cases you are talking only about a period of 2 months or 4 months or even 8 months of unemployment. And I would imagine given the cost of the full coverage provided for most employer plans, a 120-month average nationally, some higher, that in many cases laid off employees would prefer a much cheaper plan that protected them against a catastrophic medical bill. A couple of weeks in the hospital, a major episode of illness that could run into the thousands of dollars.

So what we had in mind was something like a $1,000, $1,500 deductible plan that would protect against being devastated economically during that temporary spell of unemployment. But at the same time would have a low premium cost for those who would purchase it.

Now it will be argued, Mr. Chairman, that those policies don't exist at the present time. And I would say to some degree that is true. On the other hand, the insurance companies and the employers of this country have a very good deal in the tax law today, and in the group health based plans that are the mainstay of our system. And it seems to me that in return for that good deal, from all points of view, that it wouldn't be too much to ask them to have available a low cost, high deductible plan that could be purchased right at the payroll office as the worker is picking up his last check or whatever the case may be so that he would have assured easy, ready access to at least catastrophic coverage for the duration of unemployment.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

Dave, let me start by complimenting you on the extent and the precision of your statement in outlining the nature of the concerns.

Let me also say that at our first hearing we tried to make it clear that we will continue our efforts to examine medicaid and the Federal-State role in the area of low-income access to health-insurance.

It seems to me that a major question about health insurance for the unemployed is who is going to pay for it. Do we want the burden to fall on the unemployed individual, on the employer, on the State or or the Federal Government?

The basic proposal that you have made to us, at least the guts of it, is to lay the burden on the employer and perhaps indirectly on employees by offering continuity and extension of benefits and so forth. The argument certainly can be made here that those who are working can carry part of the cost of covering themselves when they are not working or some of their coworkers.

The Dole-Durenberger approach is a combination of spreading the burden among employers and the individual unemployed person, and I would just be curious as to your reaction. Do you see a problem in utilizing a portion of the unemployment compensation check either for premium payments or for other forms of cost sharing, as long as it is realistically limited in some way?

Mr. STOCKMAN. Are you proposing a deduction from the employee's unemployment check?

Senator DURENBERGER. That's right. At the election of the individual person involved.

Mr. STOCKMAN. Well, I think that that would be a reasonable approach. I would say overall in terms of your question of where do you place the cost, the answer has to be we need to cut the cloth to fit the suit. And what we have tried to do here is define three basic generic situations. Multiworker families with one worker employed, and clearly there are cross subsidies going back and forth now and open enrollment should provide protection for that substantial part of the unemployed work force.

And then relatively well off families that have short spells of unemployment—and in that case we are saying they bear the cost, but allow them to buy into the cheaper group system rather than the much more expensively individually marketed plans.

And then the third case is the hardship cases where everything else has been exhausted or the means just aren't there. And this ought to be borne by the taxpayers through the mechanism of a block grant financed on a pay-as-you-go basis. And I would hope that sort of diagnosis would make some sense to the committee, and that we would come up with a solution based on that principle.

Senator DURENBERGER. This is not the first time this kind of discussion has taken place. It has taken place in most of the States. And as you point out in your statement, a number of States have started to move in this direction. We've had some difficulty in getting the Governors and others to come in and testify. And I don't know whether that's because they are afraid of another Federal program or afraid of the resource requirements that might come with it. But in response to a question from the chairman, you indicated that you weren't wed necessarily to the tax cap as a means of financing the program. What other options do we have?

Mr. STOCKMAN. I think you are raising a question about the source of financing for whatever Federal aid or grant that is made available. And we feel quite strongly that the logical first and preferred source would be the tax cap since we presume the committee will be enacting that anyway as part of our joint effort to improve the incentives in the health care system, and reduce budget deficit at the same time. So given that assumption, we felt that in this legislation, given the need to move fairly urgently here, this would be the proper time to address both. There are other means, but for today and for quite some time to follow, we are going to strongly

insist that it be tied to the tax cap. And that that be the form of pay as you go in funding in this area.

Senator DURENBERGER. Senator Heinz.

Senator HEINZ. Thank you.

Mr. Stockman, I think your proposal has come a very long way from some of the news reports that have surfaced over the past several days and weeks. I think you have made some very constructive suggestions about how we can change the existing system so that, for example, where there is one person employed there will be the opportunity for other members of the family, if you will, to buy in. I think your advice that this be a block grant is, in a sense similar to the legislation that Senator Specter and I introduced. It was referred to another committee because we didn't draw it quite as carefully as we might have to make sure it was in Senator Durenberger's and Senator Dole's tender mercies. One of the things I think we learned at our hearings is that in each State there are likely to be a number of options. Some States may decide that what they want to do is to permit individuals to buy in and make grants to them. Others may wish to go a more institutional route. Some may wish to do a combination of both. So the block grant approach makes a good deal of sense.

I think we would encounter many problems if we tried to design and enact an entitlement. We've been through the design of entitlement programs around here, and one thing that we know for sure is anything we do that is hastily enacted we are likely to regret, and anything good that we do is likely to take a long time.

Now as I understand your proposal—and this is my first question—what you are saying is you are willing to leave to the discretion of Congress, this committee, to what the actual amount of any such program ought to be as long as we pay for it, as long as we are on a pay-as-you-go basis. Therefore, if we decided this should be a $900 million a year program for 1½ years or through 1984, on the presumption we would have been through the worst of the problem by then and that was enough money, and we found the method of paying for it, the administration would have no objections as long as we were consistent with your other criteria. Is that correct?

Mr. STOCKMAN. That is correct, Senator. I would expect that since there is the burden of simultaneous financing and the difficulty of doing that that would keep the total authorization within some reasonable bound. But I don't think any of us know enough precisely at this moment to set a number on it. But we do know it has got to be self-financed if we are to afford it.

Senator HEINZ. Now you have suggested that we do this. To the extent that we do, it is an augmentation of title 20. Does that mean in your judgment we should put in several hundred million additional dollars on a pay-as-you-go basis; that we should use the same allocation formula as in title 20 now; or would you think it would be better policy to have a formula that targeted the money more on the basis of duration and amount of unemployment?

Mr. STOCKMAN. Although we haven't formulated any formula that we could recommend to the committee, clearly, targeting would be warranted along the lines of a principle I articulated before to cut the cloth to fit the suit. We are talking in this third

category of our diagnosis of the hardship cases—people who have exhausted their UI, the long term-unemployed—in clearly States like Pennsylvania, Michigan, and others that are going through structural change in the economy in having an entire plant shut down and people without work for substantial periods of time would have a much higher requirement for this kind of direct grant assistance than other parts of the country or the economy where it is basically cyclical employment of relatively shorter duration on average. So I would think some targeting formula that was consistent with the basic reason that we have proposed grant assistance would be warranted.

Senator HEINZ. I have one question as to the likely eligibility of individuals if title 20 is used. Title 20 has traditionally been used to target funds to people we call the categorically eligible: People who are on food stamps, medicaid, or AFDC. Now clearly, one of the reasons we are all interested in this program, one of the reasons the administration has come around in support of the extension of unemployment compensation is that we want to keep people off of welfare. We don't want them to have to ultimately end up in that kind of a situation.

My question is, do you anticipate, now that we have block granted title 20, and it is a different program than it used to be, that there will be any restrictions on the States in designing programs that will keep people, who may be in fairly desperate shape but don't want to go on welfare, from finding it necessary to go on AFDC or a similar program to gain access to this kind of help?

Mr. STOCKMAN. Well, I would point out, Senator, that title 20 is not means tested. It serves primarily a categorical population, but it's not limited to that. And one of the current and long-standing purposes has been prevention or rehabilitation so that people can become self-supporting and self-sufficient. So I don't see that this vehicle is particularly problematic. And if there are features of the law or regulations which are bare bones now, it seems to me you would want to override them for that segment of whatever money you provided to fund this purpose.

Senator HEINZ. I had no doubt that that was your goal. It should be a goal of any legislation we pass. My time has expired, but I thank you.

STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SPECTER. Thank you very much, Mr. Chairman. I thank the committee for scheduling these very prompt hearings. I think a very desirable facet of this entire procedure has been the fast tracking. We had this issue come up on the social security bill on March 23, and I think it is a tribute to the chairman and the committee that on April 27 we are in the process of having these hearings, having had a substantial amount of discussion on a couple of legislative proposals. Of course, this follows a meeting which many of us had with you and Mr. Meese yesterday at the White House. Which I think this was highly desirable.

Mr. Stockman, as a source of funding it is agreeable from the administration's point of view that other block grants which are

available to the States be made available for these people in category 3, in urgent need, in addition to whatever might be realized by changing the cap?

Mr. STOCKMAN. In principle, I think I would agree with you. There is no special reason why it has to be title 20 rather than the others. But I do think we want to avoid proliferation. We have four or five block grants that potentially could serve as a channel or vehicle, and we certainly don't want to involve ourselves in too much committee proliferation as well because of the varying jurisdictions in getting four or five or six congressional committees involved in trying to put together a bill that needs to move fairly quickly. So I would urge that you use the social services block grant. It is the broadest, the largest. It has got an institutional base to deliver and administer and manage at the State level. And that doesn't rule out the health services block grant or anything of that sort, but we feel fairly strongly that title 20 is the proper vehicle or channel for providing grant assistance.

Senator SPECTER. There may be a variety of ways to fund it, but my own sense is that a very high value is to be placed on speed. There is just a tremendous amount of need out there. As you know, some of us have other ideas as to how to handle this problem. Senator Heinz and I had a different approach on our bill S. 811. I would, for one, would be willing to defer to the administration to see if we can move it very rapidly to get it in place.

Following up on a question which Senator Heinz asked, and this is my final question, as to targeting, would the administration be willing to give a hand on promoting a targeting concept in the Congress? We had this issue arise recently on the jobs program, and it draws quite a number of objections from a number of sources. And as you point out, there are special needs for States like Pennsylvania and Michigan. I think you put those two States in that order. And if we do go toward the targeting concept, could we get some lobbying help from the administration?

Mr. STOCKMAN. Well, that always involves some delicacy in the legislative process, as you well understand. On the other hand, we justify this category 3 in terms of hardship. And what hardship really means is long duration of unemployment for most people so that their resources have been exhausted, and their unemployment insurance has been exhausted. And I think to the extent that you come up with a targeting formula that places a heavy weight on duration, long duration of unemployment, that would be an appropriate element of what we have recommended overall. And that is something that we would endeavor to try to support you on.

Senator SPECTER. Thank you, Mr. Stockman. I thank the chairman for permitting me to question him.

Senator BRADLEY. Mr. Stockman, as you know, we are in the deepest recession since the 1930's. There are 11 million people out of work today. The projections for the next several years are that there will still be a much higher number of people out of work than we find acceptable in the country. In my State of New Jersey, although our unemployment rate is generally lower than the rest of the country, there are pockets of unemployment at 14 and 15 percent. And although this is not a new problem, as you have pointed out, the numbers of people unemployed and the length of

the time that they have been unemployed, I think, are important enough to get everyone on this committee strongly supporting some effort to provide unemployment benefits to those who have lost their jobs.

The question is How do we go about it so that we can actually get something done? And you have made, I think, a very carefully crafted proposal. And I am not exactly sure how it would work if it was all put together. So what I would like to do is just get your reaction to some of the other suggestions that have been made.

What is your reaction to requiring employers to pay the premiums for unemployed workers? In other words, cover the health care benefits for the unemployed workers.

Mr. STOCKMAN. Well, Senator, I think you have a fairly serious problem with that if you mandate it for more than a short duration. In other words, proposals now do exist for 6 months or 8 months of mandatory extension. The reason for that is that it will hit those industries the hardest that are now in the throes of transition. The steel industry, the auto industry, the smokestack industries that are having both temporary, cyclical unemployment as well as longer term structural shrinkage would be impacted enormously with additional costs. And that would exacerbate the negative economic conditions or spiral that they are in now.

So I do not believe spreading the cost to the individual employer and the industries, given the enormous range of unemployment experienced, is a very good idea at all.

Senator BRADLEY. I noticed you opposed it, but what would you say to the idea of making health care benefits for the unemployed an entitlement?

Mr. STOCKMAN. Well, I think that is something that we have strongly recommended against. We think the problem there is that there are so many varying conditions among the unemployed from those who are in two worker families with high incomes despite the unemployment to those who are utterly destitute because it's a one worker family; he worked for a steel mill that closed a year ago and they have exhausted everything.

I do not believe that you can define in an entitlement that will target the resources where they are needed without providing expensive unaffordable windfall in places where there is no need at all. So that is why we have recommended trying to fill in the gaps and the shortcomings of the current system with this three-pronged approach.

Senator BRADLEY. What is your reaction to allowing those people who are unemployed to have more ready access to medicaid care?

Mr. STOCKMAN. Well, I think I would not open up medicaid directly because medicaid in primary purpose is designed for the permanently dependent. It's a means tested program and income tested program, and we are having great difficulties managing that program, financing it, controlling its cost. I think rather than relaxing the income criteria or the asset criteria, which I believe is what you would have to do to achieve your objective, it would be better to have a temporary program of a free standing nature such as through the social services or title 20 block grant to take care of those needs.

I don't think you should breach the means tested nature of the medicaid program or we are going to open ourselves up to cost exposure that is literally unbelievable when you start to calculate it.

Senator BRADLEY. You support for the very poor the use of the social services block grant?

Mr. STOCKMAN. That would be the vehicle that we have recommended.

Senator BRADLEY. And you have said that you would like to pay for this with a tax cap. I think I heard you say in response to Senator Dole that that's just your suggestion; you don't have any particular affinity for the tax cap.

Mr. STOCKMAN. No; I didn't quite say that. What I suggested was the most important principle is pay as you go financing. Any bill we get with additional Federal cost must be financed in equal dollars.

The second point I said was that our first preferred and foremost recommendation as to achieving this would be the title 20.

Senator BRADLEY. But not exclusive?

Mr. STOCKMAN. Well, I don't think you ever want to say that.

Senator PACKWOOD. But it could just as well be financed by an additional tax?

Mr. STOCKMAN. Well, I'm not going to recommend here today that we just open up the tax codes and lay on any old tax to fund this program. I think it's sensible to link the two together because in a sense what you are doing is shifting the overall cost burden for health care costs from those who are better off to those who are somewhat less well off, and there ought to be some linkage in the whole policy in that regard.

Senator PACKWOOD. Let me ask you some questions about your assumptions for the cap. Originally you set the cap at $175, now it has been lowered to $160, which you assume will pick up an additional $500 million. Do you think there is any medical cost containment achieved by the cap?

Mr. STOCKMAN. Yes; I believe there would be because over time it will cause a restructing of health coverages, and I believe it will result in higher deductibles and copayments and a better set of incentives for consumers of health care as indirectly providers of health care.

Senator PACKWOOD. Why? Because the employers will attempt to bargain down to the $175 and the unions to the $175 limit.

Mr. STOCKMAN. No; because people will want to maximize their value for the money which is tax excludeable, and, therefore, worth a lot more. Over time it should encourage innovative delivery systems, group plans, health maintenance organizations as well as greater cost sensitivity on the part of standard carriers.

Senator PACKWOOD. Well, it seems to me you have two goals which are contradictory. If, indeed, people observe the cap and they don't want to pay income in excess of $175, then they would probably reduce this coverage to the $175 limit. In that case the cap raises no revenue for the Government. Isn't that true?

Mr. STOCKMAN. Well, not necessarily. I would presume that worker and the marketplace functions on total compensation costs, not just cash wage, and you would——

Senator PACKWOOD. There is no revenue for government from the cap if the coverage goes down to the cap level.

Mr. STOCKMAN. No; I think the general presumption is that total compensation would not be reduced over time but more of it would be in the form of taxable cash wages and less in the form of tax excludeable health benefits. Now there is no scientific answer——

Senator PACKWOOD. Is that a goal the administration is trying to achieve?

Mr. STOCKMAN. It is not the primary goal or purpose. That is the predicted result based on the observations of wage behavior in the marketplace over long periods of time.

Senator PACKWOOD. One of your predecessors, Jim Lynn, would argue for just that. That we should pay everything in wages, and have no excludable fringe benefits, and let the employees use their money for what they want.

Mr. STOCKMAN. I think in some ideal economic world that might be something to talk about. But we have a history here of 30 or 40 years in which the tax code has provided preferential treatment to a variety of fringe benefit forms of compensation. And I don't think you wipe out 40 years of history practice, institutional reality, vested interest overnight or even in principle at all. But I think you have to recognize when things get out of hand. Clearly in this area they are out of hand, and the cap is a way of balancing what needs to be done economically with the realities that flow from history.

Senator PACKWOOD. I want to make sure I understand what you were saying. If an employee's coverage is now $250 a month, family coverage, and it is lowered to $175, and you go to a $200 or $300 cost-sharing or whatever it would take to make up the difference for the loss of the $75, your assumption is that $75 will go into wages or some other taxable income so that the Government will be losing no money.

Mr. STOCKMAN. I'm not sure that the assumption is 100 percent. I will supply that for the committee.

[The information from Mr. Stockman follows:]

Mr. STOCKMAN. But generally the assumption is that there is not a dollar for dollar reduction in compensation. There is a shifting from nontaxable to taxable form.

Senator PACKWOOD. You don't think if you were really a sharp union bargaining agent you would try to shift that to some other tax-free fringe?

Mr. STOCKMAN. Well, there is always that possibility. It's a question of loopholes, and it's a question of applying pressure at one point and finding reactions elsewhere. This committee is well versed in that. That's the nature of the Internal Revenue Code, and maybe down the road there would be other excesses; there would be other out of hand situations that need to be addressed. But, clearly, this is the overwhelming fringe benefit.

Senator PACKWOOD. I practiced labor relations for 5 years on the employer side, and some of the cleverest people I ever met—and I mean that in the best sense—were the union bargaining agents; in terms of figuring out how much they could get for the dollar and where the relatively slight taxable fringe benefits were.

But I think you are operating on the wrong assumption if you think health benefits will be shuttled into taxable revenues. They will start looking at life insurance; they will start looking at whatever else they can find—education benefits that are now tax free—to find some way to make sure that their employees get them, but don't have to pay anymore taxes.

Let me go even further

Mr. STOCKMAN. Mr. Packwood, if I can only say, that may well happen and that would reduce the estimates of revenues, but on the other hand it clearly would contain dollar value in the coverage structure of health benefits and our primary goal here is cost containment on the health side and incentives for more efficient economic performance. So I don't think that obviates the purpose of the justification for the proposal. It just raises questions about the revenue estimating, which is something that we would have to contend with.

Senator PACKWOOD. I think the administration is making a terrible philosophical and political mistake. One of the extraordinary things that the business community has achieved in this country is shutting off any desire for national health insurance. You can go to your steel mills or my lumber mills and you will get questions about property taxes and abortion and El Salvador and gun registration, but you don't get any questions about health insurance. You get those at the Harvard School of Medicine because they think they are going to run the system if we ever get national health insurance, and they are probably right. [Laughter.]

But what you are going to succeed in doing, I fear, is make it a little bit more difficult and maybe significantly more difficult for the average employee to afford their health coverage, and eventually they will turn and snap at us and want the Government to provide it in some way. And what it will be is a Government administered health system. And you can say we won't go in that direction. I will say we clearly won't go in that direction so long as we continue on the same path we are on. But I think you are going down the wrong path, and you will end up eventually with national health insurance if you start down the road of caps.

Mr. STOCKMAN. Well, Senator, if I could respond. I think that that is a very insightful and wise analysis. But I would also point out that the underlying inefficiencies of this health care delivery and financing system are so enormous, are so pervasive, are so deeply imbedded that the cost of the health care that we must provide for the elderly and for the poor and for others is becoming prohibitive, $10 billion in 1970, $100 billion in a year or two, $150 billion before the decade is over. And on the other hand, many people who are not provided the full Cadillac plan under the existing plan, the virtues of which you are pointing out, will increasingly be knocking on the door as the unemployed are here today in this sequence of hearings by the committee saying "We can't afford to get into that system that is being driven by a $30 billion year tax subsidy."

There is more than one route to national health insurance, and we may well be on it unless we can find some way to encourage cost control incentives and greater economic decisionmaking within the system that we have.

Senator PACKWOOD. Has the administration ever estimated how many billions they could save if they would support the home health bill that Senator Bradley and I have introduced?

Never mind. My time is up. [Laughter.]

Senator BRADLEY. I've been waiting 2 years for the answer.

Senator DURENBERGER. I have just one comment on national health insurance. And I want to agree with Dave Stockman who stated it better than I that we wouldn't be here today unless the push was still on for national health insurance. We are all recognizing that there are 5.5 million people out there without access to health insurance. And the press will be on to provide broadened coverage forever.

We already have a national health insurance system in the employment base. We have a $26 or $27 billion a year subsidized system for people who pull down $302 a month worth of tax free health coverage at General Motors or Chrysler or Ford. The national average for employer-based coverage is in the neighborhood of $120 a month. The difference between that $120 a month and the $302 a month is being picked up off of somebody's taxes in this country.

Now that's a debate that we will have to carry on under the specialized heading of preserving the special relationship between employers and their employees when it comes to health care. But the employer-employee relationship is very important in the discussion of unemployed persons because it once formed the context in which the unemployed had access to our health system. I compliment you for continually trying to pull us back in the direction of a sensible employer-based system.

I want to ask just one question that gets back to where I left off before, and that is the role of the States. I'm not sure that we ought to be designing a Federal program to solve this particular problem. It seems to me that a State-based program utilizing the unemployment compensation offices and medicaid intermediaries may make the most sense.

But as I said before, we don't have the States represented here. I don't think it's because they are insensitive to the problem. Given the financial problems that States now have and may have in the future I can appreciate their reluctance to embrace a new financial commitment. Is any program that is not totally put on the backs of the employer-employee relationship going to present us with some reluctance or even opposition from the States?

Mr. STOCKMAN. Well, Senator, I would think under current circumstances this is one burden the States wouldn't want, would strongly resist and in some sense probably can't afford anymore than we can. So what I am suggesting is to the extent that the problem can't be handled with the open enrollment provisions and the continuation of coverage provisions, to the extent that we must address the targeted hardship problem, that that ought to be a Federal grant, and it ought to be financed with equal dollars of revenue.

Now I believe it would be important, though, to have the State administer it because I have talked at some length with Senator Heinz, for instance, and he tells of episodes that are obvious and true of whole plants shutting down and 5,000 people being without

health coverage. In that circumstance the State probably could contract with the local hospital to take care of those workers for a stated period of time.

In other States, it's just the cyclical unemployment that we are dealing with, and you would use some other mechanism. I don't think we can design it here in Washington or this committee. But if we provide the financing through a block grant, I am sure the States are going to be resourceful enough to tailor the money they are receiving to the most urgent needs that they can identify in a way that's flexibly tailored to the circumstances.

Senator PACKWOOD. Senator Heinz.

Senator BRADLEY. Mr. Chairman, could I submit some questions from Senator Metzenbaum for the record for Mr. Stockman to answer? I'm not able to stay.

Senator PACKWOOD. You may. And I'm sure he will be happy to answer them.

[The questions from Senator Bradley follow:]

Senator HEINZ. I would like to talk about the tax cap for a few minutes. The administration clearly would like the Congress to act on it, and you would clearly like the Congress to act on it sooner as opposed to later. And to the extent the tax cap is in some way tied as the means of financing to this legislation to help the unemployed through a difficult period, I think it's important for us to come to agreement on some of the problems as well as some of the potential opportunities that we face when we talk about the tax cap.

Now there are three things that concern me about the tax cap over and above the fact that I think philosophically you can argue for the tax cap as a means of redistribution from middle- and above middle-income people to people who are clearly in desperate shape. There are some issues involved with how we are going to make and design our present health care system to be more efficient, to slow its very high rate of cost increase annually, and three questions come to mind.

You, when you were in the House, and I think you still are, were and advocate of procompetition, restructuring incentives for the health care system. And my first question—let me lay out all three of the questions and then you can answer all three—would be to what extent do you think the administration's tax cap would impede development of prepaid alternate delivery systems such as HMO's, health maintenance organizations. Essentially, the concern being there that they are often the startout as the more expensive plans. But they also tend over a longer period of time to be less subject to health care inflation.

Second question: Do you agree with the viewpoint that the tax cap, as we have had testimony it will, would discourage employers from hiring people who have a less than kind of healthy history? That is to say, the aged, the ill, disabled workers; people who if they were a part of a particular health care network would tend to raise the average cost, and, therefore, the average premium on which the tax cap would be levied.

Thirdly, and this is based on some studies that Blue Cross and Blue Shield Association have done on their years of experience, would you agree with the contention based on their experience that

employers and employees may, in fact, respond to a tax cap by dropping those benefits which are most cost effective, which I mean the preventive health services that don't have a high cost, but at the margin are, besides being cost effective, thought to be also not that costly to the beneficiary if they are dropped. In other words, what really happens is individuals tend to keep the high dollar, the high risk parts of their health insurance, which also happens to be in the long run the most costly because they don't want to get stuck with a $10,000 hospital bill—they will pay almost any amount to hang onto that coverage. And they really, in a sense, will be anywhere from indifferent to a lot less worried about losing those preventive health services—outpatient care, and so forth.

Mr. STOCKMAN. Yeah, I think all three of those are basic questions that have to be addressed and answered about this proposal. In the first case, though, I would not say we are not proposing to abolish the exclusion or to set it at some reasonably low level. The $175 a month is $2,100 a year. And it seems to me that if an HMO can't provide family services for $2,100 a year even if it includes some small copayments and other incentives that they are going to need anyway to reduce excessive utilization, then I am not sure you are accomplishing anything because that is a pretty generous—that is a pretty ample level of dollar resources.

Now over time, because we propose to index the tax cap to the CPI rather than the medical index, that will bite more and more. But, supposedly, over time our goal is to get health care cost escalation more in line with price escalation of the economy. So my answer is no, I can't see why that should be a major impediment given the high level of $175 a month at which we are starting.

And we estimate that that would only impact about 18 percent of the work force since the average premium value or actuarial value is in the range of $120.

Now on your second question regarding discouraging the hiring of less healthy workers, I suppose you could make some kind of highly refined case about that, but I have observed something different. And that is the basic difference in the population regarding health risk and cost exposure is between the working and the nonworking. And the nonworking by virtue of either being aged or disabled or in some condition where they simply aren't prospective candidates for being employed. Among those who are in the working population, there are differing health conditions, but I can't imagine that those differentials and the cost exposure differences are large enough to cause major changes in the group rating, which, after all, is designed to blend all of that together anyway.

So I can't see that that is a very good argument, although on the fringe, on the margin there might be some small impact. If you were trying to hire those who by definition are unemployable, then you would have a large problem. But, obviously, we are not doing that, and that doesn't enter here.

Now, third, will people drop the most cost effective coverages. I think that is something we could speculate about and make a logical case that that might happen. On the other hand, I think that is a process that will work itself out over time in the marketplace. And after all, if we are going to cap the tax privilege then it seems to me we have got to have some trust that workers and their union

bargaining agents and employers will ultimately structure a set of coverages-that the employees want most. Now if that doesn't conform with what some reformer's notion of what they should have is, well, that may be a problem. But, ultimately, we can't design that. We can't really say what is 10 to 1 cost effective preventive coverage. A lot of people have theories about it—the Harvard Medical School as Senator Packwood indicated. But I think if you put the system over time under a cost constraint you will see a shakeout and restructuring here that is sensible.

Senator HEINZ. It certainly has taken a long time for outpatient benefits to be covered under Blue Cross and Blue Shield plans. You are quite an optimist. But I suppose anybody in Government has to be.

Thank you, Mr. Chairman.

Senator PACKWOOD. Dave, we are all done with you.

Mr. STOCKMAN. Thank you.

Senator PACKWOOD. Thank you.

[Whereupon, at 2:43 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

MARCY KAPTUR
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Congress of the United States
House of Representatives
Washington, D.C. 20515

April 21, 1983

The Honorable John H. Chafee
Chairman
Savings, Pensions & Investment
Policy Subcommittee
221 Dirksen Building
Washington, D.C. 20515

Dear Senator Chafee:

In conjunction with the testimony of Mayor Doug DeGood of Toledo, Ohio, and Mr. George Haigh, representing the Toledo Economic Planning Council, I would like to submit the following statement for the record.

We in Toledo are in a particularly advantageous position to comment on the pending Urban Enterprise Zone legislation before your subcommittee. The State of Ohio has already adopted its own Enterprise Zone legislation and the Warren-Sherman project in Toledo has been designated a zone under Ohio's program. While the package of tax incentives provided by the State has helped us in Toledo to begin revitalization in the Warren-Sherman area, greater assistance is essential if the goals of the legislation to attract new business, jobs, and opportunities for the area are ever to be realized.

Assistance in the form of companion federal Enterprise Zone legislation offers useful possibilities. Federal assistance will have a much greater effect on business location decisions and economic renewal prospects in zones like Warren-Sherman than do the currently available state and local tax incentives. I believe, however, the Administration's restricted proposal falls far short of what is required. In order for Enterprise Zones to contribute to the economic revival of depressed cities, a number of other provisions need to be included in the proposed legislation.

The Adminstration's initiative is the least acceptable of the Enterprise Zone alternatives before your committee. Both the Hart and Boshwitz proposals, for example, provide important equity expensing provisions which are critical in

making available important up front capital for small businesses. Of the Senate Enterprise Zone options, the Hart bill is the best approach.

An Enterprise Zone program based entirely on tax incentives will have little more effect than providing relief at the margins regardless of the specific objectives of the program. Indeed, the problems of a zone are trivialized if we consider them only a function of tax and regulatory barriers. In order for Enterprise Zone legislation to be effective, it must be linked to a number of other efforts, as well.

Examples of necessary linkages include complementary housing and economic development initiatives, crime control, job training, and infrastructure repair. If the Warren-Sherman project does not succeed, it will be due to the lack of assistance in these significant areas. In addition, such an important undertaking requires a coordinated approach involving business and community leadership development from the affected areas themselves. The City of Toledo and the Toledo Economic Planning Council are to be complimented for their initial efforts to catalyze such activity. Thus, the overall level of assistance necessary to achieve the goals of the Enterprise Zone program throughout the nation cannot be achieved by relying on existing, uncoordinated programs at current funding levels. To think otherwise is to be unrealistic.

Mr. Chairman, you and the members of the subcommittee are involved in an important undertaking. Those of us who want to see the Enterprise Zones succeed, and who believe strongly in public-private-community sector partnerships, are looking to you to revise and redirect the federal proposal in a more coordinated manner in a way that will allow it to succeed in meeting the pressing economic development needs of our community.

Sincerely,

Marcy Kaptur

MARCY KAPTUR
Member of Congress

MK/mvm

Statement of the
American Society of Internal Medicine
to the
Senate Finance Committee
on
Proposals to Provide Health Benefits for the Unemployed
April 28, 1983

The American Society of Internal Medicine (ASIM), a national federation of 51 state component societies representing over 18,000 specialists in internal medicine, appreciates the opportunity to present its thoughts on the appropriate role of the government and the private sector in assuring that the temporarily unemployed can continue to receive quality medical care.

It has been estimated that over 16 million Americans have lost health insurance coverage as a result of unemployment. ASIM believes that there is an urgent need to assure that this temporary loss in health insurance coverage does not result in reduced access to high quality medical care. We believe that the private sector--physicians, hospitals, commercial laboratories, health insurers, and business--have a responsibility to take appropriate measures to further this goal. However, we recognize that these efforts alone cannot represent a total solution to the problem. Therefore, we encourage Congress to consider appropriate legislation to continue health insurance coverage for those unemployed individuals that otherwise (due to economic constraints) may not be able to obtain high quality medical care.

ASIM has been actively working to encourage individual internists and our state component societies to initiate activities designed to assist

the temporarily unemployed. In October, 1982, ASIM's House of Delegates, representing internist-leaders from throughout the country, instructed its Board of Trustees "to recommend to members the need for heightened awareness of patients' medical expenses and that internists should provide opportunities for patients to discuss fees." Shortly thereafter, ASIM initiated discussions with the AFL-CIO on this problem.

The AFL-CIO and ASIM agreed that the primary emphasis should be on helping unemployed individuals continue to receive care in their personal physicians' offices. ASIM believes that, to the greatest extent possible, it is important that patients be able to maintain continuity of care in their personal physicians' offices, rather than being forced into a situation where they must receive care from a free clinic or other source.

In November, 1982, ASIM President Monte Malach, MD, wrote to all ASIM members, urging them to take the first step to tell patients about their payment policies so none of them will feel unable to afford necessary care because of temporary unemployment. He noted that although physicians traditionally have had a policy on adjusting fees, making alternative financial arrangements or providing uncompensated care to patients who have lost health insurance benefits, some patients may be unaware that--or to proud or embarrassed to ask if--their physician is willing to make special arrangements. To help internists advise their patients that their economic difficulties need not be a barrier to continued care, ASIM developed a sample letter that internists could adapt to their practices and give to their patients. It expresses the

physician's concern about any temporary hardship that patients may be having due to unemployment and loss of health insurance and informs patients that they can continue to receive care. Members were urged to use this letter or other appropriate means to convey this message to their patients.

Over 1,500 internists requested copies of the sample letter. In addition, a vast majority of ASIM members surveyed indicated that they intended to use this or other appropriate means (such as posting a sign in the office, or instructing office staff to advise patients about their payment policies) to assure patients that they would be able to continue to receive care despite temporary economic difficulties.

A number of other local and national medical societies have initiated, or plan to initiate, similar programs. ASIM has recently learned that the American Medical Association is planning to advise all AMA members that they should inform patients about their willingness to make alternative financial arrangements. The AMA intends to provide its members with a sample letter (based on ASIM's letter) to assist them in doing this. The president of the Los Angeles County Medical Society also recently advised members to take similar steps, again citing ASIM's program as a model. Several other specialty societies have also initiated programs based at least in part on ASIM's effort. ASIM is pleased, of course, that our initial efforts have served as a catalyst for other programs that will reach far more physicians than our own membership.

ASIM is also working to establish local "backup" referral programs in selected communities to provide charitable care to unemployed individuals. For example the Indiana Society of Internal Medicine recently approved a program under which internists in Indianapolis will agree to see referred unemployed individuals in their offices under a reduced fee or charitable basis. The Maryland Society of Internal Medicine has been instrumental in encouraging the Baltimore City Medical Society to establish a similar referral program. ASIM will be working with other state component societies to develop similar "backup" referral programs.

However, it is important to recognize that physicians cannot provide the entire spectrum of care on their own. Hospitals, commercial laboratories, and other suppliers of service must also due their part. Businesses should take reasonable steps to continue health insurance for temporarily unemployed workers. Health insurers should also take appropriate measures to continue coverage as long as possible.

ASIM also believes that there is a need for legislation to assist those patients who otherwise would "fall through the cracks." In 1981, ASIM's House of Delegates approved the principle that "pro-competition legislation must provide for coverage of those who can't otherwise get health insurance because of employment or health status." ASIM's House also endorsed the concept that there should be a cap on employer deductibility of contributions to health insurance plans, and that all employer-sponsored health insurance plans should meet certain standard benefit requirements as a condition of tax deductibility. Congress is currently considering legislation proposed by the Reagan administration

to implement these principles. ASIM believes that Congress should enact the proposed cap on employer contributions and require all plans to meet certain standard benefits, such as coverage for catastrophic illness and outpatient services. Although the primary purpose of these proposals is to encourage the selection of more cost-effective insurance plans, ASIM suggests that any revenue resulting from the tax cap could be applied to providing health insurance for unemployed individuals. The benefits offered to unemployed individuals should include coverage for outpatient services, preventive services and catastrophic illness.

In conclusion, ASIM would like to reiterate its commitment to promoting private sector efforts to assist unemployed individuals in continuing to receive quality medical care. We also urge Congress to consider appropriate legislation to provide health insurance to individuals who otherwise cannot receive coverage because of employment status, and to specifically consider enacting the proposed tax cap (with appropriate standard benefit requirements) to help provide a source of funds for this type of program.

BD/be
G2-3395

AMERICAN DENTAL ASSOCIATION

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May 11, 1983

The Honorable Robert J. Dole
Chairman, Senate Committee
on Finance
2227 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Dole:

I am writing to express the views of the American Dental Association concerning the provision of health benefits for unemployed individuals. I request that this letter be included as part of the record of the hearings the Finance Committee held on this issue.

The ADA shares the concern of members of this Committee and the Congress over the problem of assuring continuation of health insurance benefits for persons who have lost that protection through unemployment. Many currently unemployed individuals do not have sufficient resources to maintain entitlement to their health benefits. Therefore it is appropriate and desirable for the government to assist them on a temporary, emergency basis.

In this connection, we believe that the most efficient and effective approach would be to establish a program which supplements employer coverage. The government would pay, from general revenues of the treasury, premiums and necessary administrative expenses directly to carriers who continue pre-existing benefit coverage on behalf of persons who would have been entitled to these benefits had their employment not been terminated.

We also must take this opportunity to express our opposition to the imposition of a tax on employee health benefits as a mechanism for financing a program of health insurance for the unemployed or for any other purpose. We do so at this time because there has not been an opportunity to formally present our views on this proposal as an independent issue. Such a basic change in national health policy should not be enacted without a thorough consideration of its consequences and without receiving the views of representatives of those who will be most directly and seriously affected.

It is the basic position of the American Dental Association that health benefits should not be taxed. The current tax system which has assisted the development of employer based health benefits protection for the majority of American citizens represents valid social policy. This approach, which permits employer deductions for health benefits payments and does not tax employees for these contributions, has assured protection against health expenses for the majority of Americans without the need for an expensive and less efficient government financed health care system.

It is our understanding that two fundamental reasons have been advanced in support of the proposal to tax employees on certain employer health benefits contributions. These are that revenues will be raised and that increases in health care costs will be moderated because individuals will be encouraged to modify their health benefits protection in order to eliminate any tax consequences.

It is the strongly held opinion of the American Dental Association that neither goal is likely to be attained. Further, to the extent that either is reached the other cannot be. If health benefits plans are modified to avoid tax consequences, revenues will not be raised. If revenues are raised, the expected modification in benefits will not occur.

It is our position however, that there will be a significant modification in benefits to avoid tax consequences. Unfortunately these modifications will be in dental health coverage and similar benefits which are not contributing to the rising health care cost problem, and in fact have led the way in demonstrating mechanisms for moderating these increases.

If faced with a federal policy which will impose some tax consequences, it is only logical that individuals will assure that they are comprehensively protected against the high costs of hospitalization and major medical procedures. Imposing a tax such as that proposed in S.640, the Health Cost Containment Tax Act, will not change individual demand for comprehensive coverage in these areas. Individuals will continue to be insulated from the cost consequences of the most expensive elements in our health care system.

Employees with dental or certain other types of health benefits protection who would be subject to this tax will very likely cause their employer's contributions to be switched to other non-health, untaxed fringe benefits. The result not only will be a loss of revenues, there will be a loss of a very cost effective benefit to the employee. Along with the cost effective nature of dental benefits has been a consistently improved oral health for individuals with these benefits. The ADA is absolutely opposed to a proposal which will not attain either of its goals but will result in a negative impact on the oral health of the American people. This legislation should not be adopted independently or as a mechanism for financing a program of health benefits for the unemployed.

Sincerely yours,

James P. Kerrigan

James P. Kerrigan, D.D.S.
Chairman
Council on Legislation

American Hospital Association

AHA

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SENATE COMMITTEE ON FINANCE
ON
HEALTH INSURANCE COVERAGE FOR JOBLESS WORKERS

April 21, 1983

The American Hospital Association, on behalf of its 6,300 institutional and 30,000 personal members, is pleased to present its views on health insurance coverage for unemployed workers. This issue is one of obvious interest to health care providers, as well as many others in the private and public sectors who have faced the problem of assuring continuity of community health care during the recent period of sustained high unemployment.

The AHA commends the efforts of this Committee and others in Congress to provide some form of assistance to those who have lost job-related health insurance benefits. In many communities, hospitals, physicians, insurers, business, and labor are making special efforts to meet the needs of this population group. State and local governments also have joined or supported these voluntary initiatives in many instances. The point we would emphasize is that federal legislative efforts should build on and support local initiatives already in place, ensuring that federal programs do not displace private-sector and state and local government programs.

Nature and Significance of the Problem

Approximately 12.4 million Americans, or more than 10 percent of the labor force, currently are unemployed. Even with improved economic conditions, high levels of unemployment are expected to continue for several years. The Congressional Budget Office indicates, for example, that unemployment rates will exceed 9 percent through 1985. With over 90 percent of the private, non-farm labor force receiving health insurance benefits through employment, the great majority of the unemployed--an estimated 14 million to 21 million individuals, according to CBO--are without health insurance protection.

For most of the unemployed, the question is not one of access to health care services but the cost of such care. Many who formerly purchased coverage for themselves and their families no longer are financially able to do so. They allot limited resources to other necessities such as food, shelter, and clothing. In addition, loss of employment means a loss of eligibility for group insurance rates and matching employer contributions. According to Alexander and Alexander's Human Resources Management Groups, the annual premium for the worker who converts from group coverage to individual coverage averages $1,200 to $1,800 a year. An unemployed individual receiving unemployment insurance benefits surely cannot afford such coverage.

It should be noted that, within the broader issue posed by loss of employment-related health benefits, there are two separate problems. The first pertains to the "temporarily" unemployed, persons for whom there is a

reasonable prospect of regaining employment-related health benefits as the economy recovers. For these persons, public and private actions can provide effective interim assurances of access to needed health services. The second problem pertains to the "structurally" unemployed, persons who are unlikely to be rehired because of fundamental economic problems in a particular industry. Assuring access to health care (and other necessities) for these persons is likely to require a longer-term response in the form of economic assistance and employment retraining.

For either group, health problems could be substantial and are cause for concern. Many unemployed workers, for example, are postponing needed medical care because of lost health insurance. That circumstance, particularly with regard to preventive, prenatal, and post-partum services, ultimately will cause more severe and costlier health problems in the future. We fear that the incidence of stress-related illnesses among the unemployed is already on the rise, and infant mortality rates, especially in high-unemployment communities, have increased. In Michigan, the state with the highest unemployment rate in the country, the infant death rate rose 3 percent from 1980 to 1981 to 13.2 deaths per 1,000 live births from 12.8 deaths in 1980. In the same period, the national rate declined by 6.4 percent, to 11.6 deaths per 1,000 live births.

Hospitals and other health care providers share the nation's concern over such setbacks in community health. We regard the human suffering that has resulted as intolerable and foresee long-term effects on community health resources.

In the face of high interest rates and general economic pressures, coupled with substantial reductions in payment levels under Medicaid and other federal programs, hospitals and physicians have limited resources with which to respond to a growing population of under-insured and uninsured. Rising levels of bad debts and charity care, which are not recognized by Medicare and Medicaid, are threatening the financial viability of some providers. Generally, hospitals that traditionally have provided substantial services to the publicly sponsored and indigent populations in their communities are hurt most. A study conducted jointly by AHA and the Urban Institute--a survey of 453 hospitals of which 13.3 percent were public facilities--indicates that large public hospitals averaged about $32.8 million in free care to the poor, compared with $16.8 million for small public hospitals, $9.5 million for large private hospitals, and $3.4 million for small private hospitals.

The situation presages a significant long-term problem of gradual but substantial erosion of health resources in economically depressed communities, particularly inner-city areas. It will be difficult and costly to restore these lost resources, even with substantial improvement in the economy.

Recommendations

The AHA strongly supports creation of a federal program designed to assist insurers and providers of health care to continue providing quality care to displaced workers and their families. The public and private sectors must share responsibility for these workers equally; federal efforts should not

displace this responsibility nor act as a disincentive for innovative private-sector approaches. Federal legislation must be flexible and should encourage state and local governments in partnership with the private sector to develop cost-effective programs which target aid quickly and efficiently to communities with the greatest need. We would encourage limited eligibility criteria and a minimum benefit package which includes preventive, prenatal, post-partum, inpatient, and emergency hospital services.

S.951

The legislation introduced by Senators Dole, Durenberger, and Heinz addresses many of these concerns. Under S.951, all states would be eligible for federal matching grants between June 1 and September 30, 1983. Beginning on October 1, 1983 only states with insured unemployment rates at or above 4 percent would receive 80-percent matching grants; states with insured unemployment rates exceeding 5 percent would be eligible for a 95-percent match.

The Dole bill would authorize $750 million in each of the next two years to finance grants to states and $150 million per year to cover administrative costs. Coverage would be limited to six months after the eligible worker lost unemployment insurance benefits or one month after re-employment, whichever occurred first. Program benefits would be limited to inpatient hospital services, emergency outpatient services, physician services, and prenatal and post-partum care. States would have some flexibility in determining the scope of services provided; however, in no case could benefits exceed those offered under the state Medicaid program.

The bill also would authorize a premium contribution of up to 8 percent of an individual's weekly unemployment check and would provide for deductibles of up to 10 percent of a state's average monthly unemployment benefit. Finally, the program would be administered through state Medicaid agencies with eligibility determinations left up to state unemployment compensation offices.

In general, AHA supports the intent of S.951. Federal funds would be available quickly to all states, with maximum matching allotments to states experiencing highest insured unemployment rates. We do, however, believe that these contributions should be modest and not become a disincentive to health care coverage. AHA also fully supports the premium and cost-sharing options provided in the bill as an appropriate contribution by the unemployed individual to the cost of health care. AHA also favors the nature of the benefit package provided in S.951 and would encourage the committee to review the feasibility of including catastrophic coverage. The funding level of $750 million with $150 million for administrative costs is adequate and would certainly have a positive impact on programs serving this population group.

AHA is concerned, however, with three aspects of S.951. These concerns relate to eligibility, application procedures, and the use of state Medicaid programs as the primary administrative vehicle.

Eligibility: While AHA fully supports the notion of limited eligibility criteria, we fear that the definition set forth in S.951 may be too

restrictive. Limiting coverage under the program to workers who have collected or exhausted unemployment insurance benefits over the last year may in some cases prove inequitable and will in fact provide assistance to unemployed workers who are "best off." We believe eligibility must reach back at least two years from enactment of the program to have a significant impact on the millions of workers in need of health insurance coverage.

Application Procedures: AHA is concerned that several provisions in the bill, particularly those pertaining to cost-sharing and the state match, may cause states to choose not to apply for program support. We believe that alternative provisions must be established to allow other interested parties--cities, counties, groups of physicians, or hospitals--to contract directly for federal matching grants and to waive cost-sharing requirements on a case-by-case basis. A six-month waiting period could be established to assure preference to state governments.

Medicaid: AHA is concerned that administrative use of the Medicaid system will shift the burden from the private sector to the public sector and act as a disincentive for innovative and efficient programs already in place. While in some states the Medicaid program may be an appropriate mechanism, in other areas alternate approaches may be more productive. We encourage the committee to incorporate broad waiver authority which would allow states the opportunity to consider the availability of other resources in the community, including contributions from local governments and the private sector, and to evaluate alternate reimbursement proposals such as vouchers or capitation arrangements.

Again, we commend the efforts of the Finance Committee to provide needed health care coverage to the unemployed. We stand ready to assist the Committee and lend our support to those efforts.

Statement

of

the American Dental Hygienists' Association

Health Insurance for the Unemployed

The American Dental Hygienists' Association, representing 30,000 licensed dental hygienists in the United States, wishes to comment on recent proposals, introduced by the chairman of the House Commerce Subcommittee on Health and the Environment and the chairman of the Senate Finance Committee, describing plans to provide health insurance for the nation's unemployed. Mr. Waxman's bill was introduced as H.R. 2552 and Senator Dole's as S. 951. This statement will also allude to OMB Director David Stockman's testimony during the Senate Finance Committee hearing of April 27, 1983, when he stated the Administration's position on health insurance for the unemployed.

On the basis of testimony presented during both House and Senate hearings, the idea of providing health insurance for the unemployed has broad support among health professions organizations, such as, the American Medical Association, American Hospital Association, and also among labor unions, chiefly the AFL-CIO. However, there does not seem to be any consensus about the specifics of the design or financing of such a program. There are wide conceptual differences between H.R. 2552 and S. 951, relating to implementation schedules, numbers of unemployed people to be covered, annual authorizations needed and mechanisms for paying for the program. These differences are substantial and the debate over which plan would be best to initiate, in our view, should be extended rather than terminated, after only one hearing in each chamber of the Congress.

The Association was particularly interested in OMB Director Stockman's testimony, as presented to the Senate Finance Committee. The Administration appears to be opposed to the proposals, fearing the establishment of a new entitlement program in the billion dollar range. But the caveat is offered that "The Administration could support such increased funding (of a health insurance program for the unemployed) only if additional revenue measures are enacted to finance whatever incremental increase the Committee finds appropriate. Specifically, the Administration would support simultaneous enactment of the Administration's proposed cap on the exclusion of employer contributions from Adjusted Gross Income as an acceptable method of financing."

Before this testimony was presented on April 27, the Administration had proposed taxing employee health insurance benefits when they exceeded $70 per month for single persons, or $175 per month for the employee whose family was covered. The so-called "tax cap" was touted by Mr. Stockman as a new source of badly needed tax revenues. The Department of Health and Human Services proclaimed the "cap" would be a significant health cost containment device. However, very suddenly -- and may we say, to our dismay -- taxing

employer-paid health insurance fringe benefits has been linked to proposals for providing health insurance for the unemployed. It is our view that this linkage is not merely unfortunate. It could be disastrous. Taxing employer-paid health insurance benefits and providing health insurance for the unemployed are issues which Congress should address separately, debate separately and implement separately. Both proposals merit extensive consideration, both by Congress and by the Administration, because they are precedent-setting as they affect the nation's economy and the nation's health policy.

The Association believes that the Administration's proposal to tax workers on a portion of employer-paid health insurance benefits can be faulted for several reasons:

- Preventive care services may be reduced; e.g. dental care, vision care, mental health services and alcohol and drug abuse services -- all of which are commonly included in group insurance plans -- may be eliminated by employers, in order to reduce premium rates; eliminating these services would have little impact on the cost of hospital care;

- Taxing dental care benefits over a stated level will have a serious adverse affect on the dental health of one third of the U.S. population;

- Older workers, who need health care services more frequently, would be adversely affected by high premium costs, while younger workers may not be taxed at all;

- Revenues from the "tax cap" proposal, estimated at $2 million and up, cannot be validated; employers can select benefit packages in such a way that their health insurance contribution will be below the taxation level;

- Regional variations in the cost of health care would be unfair in high cost regions and over-generous to people in low cost regions.

The Association objects to the proposed "tax cap" proposals for the reasons cited above. In addition, however, we believe strongly that the suggestion to link the "tax cap" idea to the plan to provide health insurance for the unemployed is not advisable. It should be rejected. Many group health insurance plans already include

set-aside funds which are now used to extend health insurance benefits to the unemployed. Congress needs to get all its facts together, not only regarding the extent to which health insurance benefits are available to the unemployed but also it needs to examine more carefully the estimates of new tax revenues which the Administration has reported.

We recall that the Administration's initial justification for taxing health care benefits was two-fold: 1) to produce badly needed new tax revenues for the Treasury; and 2) to serve as a mechanism to control the rising cost of health care. The proposed linkage of the "tax cap" plan to pay for a health insurance program for the unemployed would therefore be self-defeating to the first justification and would have no major impact on the second.

Taxing Health Insurance and the so-called "Tax Cap"

The Association's purpose in preparing and transmitting this statement to appropriate committees of Congress and to selected agencies of the Executive Branch of the government is to urge them to treat the issues of taxing employee health insurance fringe benefits and providing health insurance for the unemployed as totally separate problems, each of which is fraught with major implications affecting the economy and the health of the people of this country. A facile, transparently designed scheme to link these two issues in the current dialogue over health insurance plans for the jobless should not be allowed even the slightest chance of serious consideration by responsible congressional committees or by officials who direct principal agencies of the Executive Branch of government.

We implore you not to let this strategy in the political arena divert you from giving serious attention and thought and analysis to two major problems in society today which do not lend themselves to simplistic and expedient solutions.

It should be clear at this point, that the Association is not expressing its opposition to proposals developed thus far to provide health insurance for the unemployed. On the other hand it should be clear that in our view Congress should not be in great haste -- despite evidence of need -- to enact legislation without further study and deliberation, no matter how much time may be required. Finally, it should be clear that the Association strongly

recommends that Congress must, for the public good, take up separately measures dealing with health insurance for the jobless and taxing employer-paid health benefits.

The American Dental Hygienists' Association represents professional, preventive oral health specialists whose members are educated and credentialed to provide preventive dental care. We, the Association and its members, want to have an opportunity to present our views on the proposed tax cap on employer-paid health insurance fringe benefits. This statement was prepared to reflect our very deep concern that an issue as controversial as this might not even be brought to a public forum for debate during a congressional committee hearing. Rather, we could anticipate that for whatever reasons that seemed expedient, the "tax cap" implementation could conceivably be enacted, unnoticed and undebated during the next budget reconciliation process which Congress used in August of 1981. Congress will not serve its constituents well in 1983, if it again funds the government, as in the Budget Reconciliation Act of 1981.

In this statement the Association urges the health committees of Congress and officials of Executive Branch agencies to permit an open debate on the proposal to place a "tax cap" on health care fringe benefits. Frankly, we are concerned that Congress may enact such a tax, for any of the reasons which have been propounded by OMB or HHS or Senator Dole, absent such an open debate.

The committees and agencies to which this statement is directed by this time are quite aware of the position of the dental profession opposing any tax on the nation's health. The American Dental Association's brochure, Taxing the Nation's Health, widely circulated in March, 1983, includes the American Dental Association's analysis of health incentive reform legislation. The American Dental Hygientists' Association agrees with the ADA analysis and its opposition to imposing a tax on employer-paid health insurance benefits. We also urge Congress to reject any proposal to tax health benefits for the following reasons:

- the tax will not control health costs significantly;
- the tax will not generate the predicted revenue;
- the tax will jeopardize dental care for 87 million people who are currently covered by employer-paid dental insurance plans and adversely affect the oral health status of one third of the nation's population.

The health committees of Congress and officials of Executive Branch agencies also are aware that a broad Coalition under the auspices of the Health Insurance Association of America is opposed to the taxing of health care benefits. This Coalition includes labor unions, professional associations, representatives of business and industry and members of Congress. The Association supports the activities of this Coalition and, with its members, urges Congress to reject any legislative initiative to tax health insurance.

The Association believes that public debate in the form of scheduled hearings by appropriate health committees of Congress is all but mandated when such a wide segment of both public and private sectors has been galvanized to act in concert to oppose the so-called "tax cap" initiative in the 98th Congress. No simplistic solutions to this debate, in our view, should be allowed to intrude on the deliberations of Congress on this issue. The Association believes strongly that linking health insurance for the unemployed and the tax on health insurance benefits is a simplistic, not a deliberate and reasoned solution.

Federation of American Hospitals
Michael D. Bromberg, Esquire, Executive Director

National Offices 1111 19th Street, N.W., Suite 402
Washington, D. C. 20036 Telephone 202 / 833-3090

May 2, 1983

The Honorable Robert Dole
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I wish this statement to be included in the printed record of the Committee's hearings on health insurance for the unemployed.

The Federation of American Hospitals wishes to express its support for legislation ensuring greater access among the unemployed to private health insurance coverage. This short term critical problem should be addressed by the Congress, however, it does not call for the enactment of a new broad federally financed, and administered regulatory program. Given the pending insolvency of the Medicare Hospital Insurance Trust Fund and the current federal deficit a new source of financing any proposal is essential.

We believe that adequate access to insurance for the unemployed can best be achieved by requiring employers to provide continuation of insurance coverage beyond termination of employment and mandating an open enrollment period to enroll unemployed spouses. Employer plans not providing such coverage should lose a portion of their tax deductibility of insurance premiums. The Federation supports a tax cap on all employer paid premiums and urges that additional revenues gained from the cap be targeted to provide funding for those not covered through the purchase of continued private coverage.

The Federation supports the provisions in S. 951 allowing States to require cost sharing by beneficiaries for services as well as the provisions in both S. 951, S. 811 and H.R. 2552 allowing financing of premiums up to a certain percentage of the beneficiaries unemployment insurance payment.

We look forward to working with members of this committee in developing an effective response to the needs of the uninsured unemployed.

Sincerely,

Michael D. Bromberg
Executive Director

STATEMENT

BY

INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES, INC.

TO

SENATE FINANCE COMMITTEE

REGARDING

HEALTH CARE FOR THE UNEMPLOYED - HEARING APRIL 21, 1983

The Interstate Conference of Employment Security Agencies, Inc. (ICESA) appreciates the opportunity to present comments regarding proposals to provide health care for the unemployed. ICESA is the organization that represents administrators of state unemployment compensation laws and public employment offices throughout the country.

The loss of health insurance is one of the most frightening aspects of unemployment. The Senate Finance Committee is to be commended for addressing this serious problem. Our comments are made from our viewpoint as administrators of the unemployment insurance system and are limited to the role that the system would play in determining eligibility for health care coverage.

S.951 places certain limits on coverage. Only those receiving regular, extended, Federal supplemental compensation and railroad unemployment compensation would be eligible. A few states pay state financed "additional benefits" during periods of high unemployment. It would seem that individuals receiving those benefits should also be included as potentially eligible for coverage.

States are prohibited from providing coverage for the first six weeks during which an individual is eligible for compensation. This could be interpreted as the first six calendar weeks after a claim is established; or, after the individual has been certified as eligible for benefits for six weeks. There are often interruptions in the claims sequence due to temporary employment, illness, failure to search for work, etc. The intent of this provision should be clarified.

States can provide coverage only to individuals who were enrolled in a group health plan offered by their last employer. There will be instances in which an individual, after being laid off from a permanent job, will take temporary work before filing for benefits. It seems unfair that these individuals would not be eligible for health care coverage. This requirement would also discourage UI recipients from taking temporary work during their benefit year. A possible remedy would be to permit coverage for those who were enrolled in a group health plan offered by their last employer or any base period employer.

States are permitted to make a deduction from the UI weekly benefit amount as a premium for coverage. This money must be used for either the state share of the program cost or to provide additional services. States hard hit by high unemployment would likely opt for a deduction from the weekly benefit to raise money for the state match. Many states believe that they will be required to make a state law change before they can make such a deduction from UI benefits.

In addition, the weekly premium may not exceed 8% of the compensation for which the individual is eligible "for such week". Several questions arise in connection with this provision. Does the compensation include dependents allowances? Is the premium meant to be reduced when the benefit check is reduced due to earnings?

States are permitted to provide coverage to individuals who were eligible for compensation within the prior 30 days but lost eligibility due to reemployment. UI recipients are not required to notify the state agency when they return to work. Some simply stop filing for benefits and are never heard from again. Therefore, we would not be able to identify this group. Perhaps an alternative would be to provide coverage for four weeks after the last week for which the individual was paid UI benefits.

We appreciate the opportunity to make these essentially technical comments regarding S.951. There is just one more point we would like to present. The unemployment insurance system is strong and resilient, but there are limits to its ability to take on additional responsibilities. During this recession, it has absorbed the shocks of an enormous increase in claims and three federal extensions of benefits. Child support intercept and changes to the eligibility requirements for former military personnel have been implemented. Due to financial constraints, our data processing capability lags behind the available technology. Implementing health coverage will be a very tough job for most states; some estimate that six months will be needed. In spite of these difficulties, we stand ready to do our best to implement whatever plan for health care that Congress agrees upon and state authorities choose to participate in. We do ask, however, that you consider the strain that the system is under and the administrative impact of the provisions you adopt.

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National Conference of State Legislatures

Office of State Federal Relations

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President William F. Passannante, Speaker Pro Tempore, New York Assembly

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POLICY ON HEALTH INSURANCE FOR THE UNEMPLOYED

The downturn in the national economy has resulted in unusually high rates of unemployment affecting millions of our citizens through no fault of their own. One of the effects of this widespread unemployment is reduced access to health insurance protection because of the high costs of health insurance premiums. Most citizens have health insurance coverage through a group policy offered through their employer. Separation from employment not only eliminates the employer paid benefit but also often results in a complete loss of group coverage. Nearly 11 million individuals lack health insurance because of the lack of employment.

Congress is currently examining methods to provide health insurance for the unemployed on a temporary basis. NCSL believes that it is appropriate for the Congress to enact legislation to provide federal assistance for those dislocated by the national economy. NCSL urges the Congress, however, to limit state matching rates so that states experiencing severe fiscal pressures will have the necessary resources to participate in the program. All states with high unemployment rates should have the option of participating in such a program. Special consideration should be given to states with regions of high unemployment, even though the state falls below the established target rate.

NCSL believes that states should have the flexibility to target assistance to those most in need and to use cost effective means to provide this assistance. States should also be allowed to establish the cost of the premiums and any cost sharing payments.

NCSL believes that all individuals should have financial access to health insurance. The decision to obtain such insurance must be made by the individual. We call on the private sector to join with governments in providing such access by allowing employees to switch their type of coverage if a spouse loses this protection through unemployment.

Adopted at the State-Federal Assembly
April 15, 1983

May 12, 1983
P.O. Box 9513
Arlington VA 22209

TO: Hon. Robert Dole
Chairman
Senate Committee on Finance

FROM: Health Care for the
Unemployed Committee

Subj: Passage of a Bill by Congress for
Medical and Health Care of Qualified
Unemployed and their Families.

A RESOLUTION

WHEREAS, the American people are compassionate citizens and concerned with the economic and social plight of our unemployed, and the effect upon their families, and

WHEREAS, our serious unemployment problem is beyond the control of most of our unemployed in varied types of occupations, and who, heretofore, have had health care insurance protection in terms of our estimated figure of 10.1 million people, and

WHEREAS, we believe that the qualified unemployed should receive some form of medical and health care with financial assistance from the Federal Government through, if politically possible, the immediate passage of some form of legislation to financially assist these people, whose problem is a national problem of concern to all our citizens, and,

THEREFORE, we ask the Senate Committee on Finance, and Congress, to expedite the passage of legislation for relief of such unemployed, and their families, and we go on record in support of S. 951 introduced by Senator Robert Dole, Chairman, Senate Committee on Finance.

Pierce McDonnell, III

Pierce McDonnell, III
Counsel and Secretary,
Health Care for the Unemployed
Committee

(202) 269-3009

5/12/83.

Senator Dole,
The original with four copies delivered by hand to Ed, of your Committee staff.
P. M. D.

Statement on

Health Insurance for the Unemployed

By

Douglas A. Fraser
President, International Union, UAW
Chairman, Health Security Action Council

Mr. Chairman, my name is Douglas A. Fraser. I am President of the United Auto Workers International Union and Chairman of the Health Security Action Council. I speak on behalf of more than one million active and retired members of the UAW, as well as the more than 100 distinguished leaders and 70 consumer, labor, senior citizens, farm, religious and other public interest groups which comprise the Health Security Action Council.

We commend this Committee for addressing the tragic loss of health protection by families of the unemployed, which is one of the most cruel by-products of the current economic depression.

The extent and the seriousness of the loss of health insurance is well known. The Congressional Budget Office has estimated that 14 million unemployed workers and their dependents were without health insurance in February and that 21 million will lose protection some time during this year. Our estimates are even higher. According to a Department of Labor study, close to 60 percent of workers lose their health protection immediately or within a month of layoff. Only 20 percent have protection continued beyond 3 months.

The cost of purchasing non-group insurance policies has soared beyond the severely reduced means of families of the unemployed. The family premium for a UAW-General Motors policy in Michigan is currently $302 per month. Converting this to individual payment with substantially fewer benefits costs about $200 per month. That is why the rate of conversion to this coverage in Michigan is only about 5 percent.

The limited family budget of the unemployed worker is seriously strained by competing essential priorities. Mortgage or rent payments, threatened utility cut-offs, merely putting food on the table are the harsh everyday realities. There is no money for health insurance. And receipt of necessary medical treatment is often ignored, or delayed with sometimes severe consequences, in the struggle for day-to-day survival.

At the same time, researchers have documented the strong relationship between job loss and higher rates of illness and death. High rates of unemployment are associated with dramatic increases in suicide, homicide, fatal heart disease, cirrhosis of the liver and other stress-related illness. Excessive drinking, smoking, anxiety, insomnia and high blood pressure are symptoms of joblessness that add to the despair, tension and depression experienced by families with a laid-off breadwinner.

According to the chairman of the President's Council of Economic Advisors, this problem will not readily diminish with economic recovery. He expects high rates of unemployment to persist for up to five more years.

Under major UAW contracts, health insurance coverage for laid-off workers continues for up to a year depending on length of seniority. But these contractual benefits are not typical for most workers, nor for many members of our Union who lose coverage at the point of layoff. I must tell you with deep sorrow that, even with the extended health insurance coverage, at least 300,000 laid-off UAW members have lost health insurance protection for themselves and their families. Most of them are denied Medicaid coverage because they are not considered poor enough.

Many public and non-profit community hospitals currrently find their existence threatened by the increase in free care they must provide to jobless patients. Many may not be able to continue to meet this need.

Recognition of the serious plight of the jobless has spawned a number of voluntary efforts on the part of community leaders, labor unions, hospitals and physician groups around the country to provide some health care services for families of those on layoff. These are helpful and commendable activities which should continue. They hardly begin to solve the problem, however. The information we receive from UAW local unions and regional offices around the country indicates that: (1) such efforts are very spotty; (2) they have served relatively few in relation to the known need; (3) they seldom provide the financial support to pay for expensive services, such as hospitalization,

when needed; and (4) laid-off workers who have always provided for their families' needs are usually too proud to ask for charity care, except in the most urgent circumstances.

We know from experience that voluntary efforts, though commendable, cannot meet a problem of such dimensions. The American Medical Association, a leader in efforts to provide help through voluntary services, testified to this effect in April of this year.

Mr. Chairman, I submit that this severe problem is national in scope and cries out for a strong national solution. It cannot be remedied by "catch-as-catch-can," unfunded, voluntary activities which may or may not take place in local communities around the country.

The economic and human consequences of this extensive loss of health care protection are difficult to project with certainty. The cost to the nation in damaged and lost lives may be as costly as the loss of productive employment itself. For the past three years, calls by leaders of our Union and others to address this situation all too often have seemed to fall on deaf ears, while the disaster mounted. Against this background of frustration, we now welcome the genuine interest on both sides of the aisle, in both houses of Congress in stepping up to this responsibility.

Because of the large number of unemployed due to the current depression, and because of the tremendous and continuing inflation in medical care, providing health care protection for the unemployed will not be cheap. The problem cannot be papered over with inexpensive or cosmetic measures.

We believe that any legislative proposals to provide health care for the unemployed should incorporate the following principles:

1. First, the program should not require a means test for determination of eligibility for benefits, as some have proposed, and which members of our Union and other laid-off workers would find abhorrent.

2. The program should set reasonable national standards for eligibility, covered services and cost sharing for this vulnerable population group.

3. The program should provide greater federal support for states which have been hardest hit by unemployment, and therefore, are least likely to have financial resources for this cause. In particular, no state matching funds should be required for those states racked by the severest unemployment.

4. The program should provide preventative care and diagnostic services, as well as prenatal and post partum care; it should not simply focus on catastrophic care. We believe any program should, at a minimum, match Medicaid benefits.

5. Cost sharing in the form of premium payments or copayments and deductibles must be minimal, recognizing the reduced circumstances of the unemployed. Copayments and deductibles should be no more than those required by state medicaid programs.

6. Due to the longstanding nature of the current economic downturn, any program should reach back as far as feasible to include the long-term unemployed who have exhausted unemployment benefits, the group hardest hit and most in need.

7. Providers who participate in the program must accept assignment.

8. Special assistance in the form of a grant program should be provided for public hospitals in high unemployment areas. All too often those public hospitals are the providers of last resort for growing numbers of low-income individuals who will continue to be without any private or public health coverage, even if a program along the lines we are discussing is enacted.

9. Since public employees are faced with unemployment problems comparable to their counterparts in the private sector, all provisions of the program should be made applicable to public as well as private employees.

A number of bills dealing with the problem of health care for the unemployed are currently before this Committee. Of these proposals, we believe that S. 951, which was introduced by Chairman Dole together with Senators Durenberger, Heinz and Specter, represents the best approach towards helping to meet this pressing need. We would like to commend the leadership displayed by you, Mr. Chairman, and Senators Durenberger, Heinz and Specter, in developing S. 951, which we see as a first step in attempting to provide health care protection for the unemployed.

We have a number of reservations about the funding and structure of this proposal. Most importantly, the proposed authorization for health care benefits - $750 million in each of the next two years - is not nearly sufficient to adequately address the problem. The Congressional Budget Office has estimated that approximately $6 billion would be required to extend even limited Medicare benefits to those who have lost their health insurance. We believe, therefore, that the authorization in S. 951 should be substantially increased, so that a larger portion of the health care needs of the unemployed can be addressed through this legislation.

We also have reservations about the structure of the block grant approach embodied in this proposal. Although the bill establishes certain maximum limits with respect to eligibility, covered services, and duration of benefits, the states are given broad discretion in setting the actual parameters of their programs. Because the amount of funds authorized under the bill would not be sufficient to enable the states to establish programs along the lines set forth in these maximum limits, the states would inevitably be forced to scale back the programs which are ultimately put into place. Moreover, as presently drafted, S. 951 does not even contain any guarantee that the funds will be used by the states actually to provide health benefits to the unemployed, which is the most pressing need. We would therefore recommend, at a minimum, that the legislation be modified to require the states to use the funds to

provide health benefits to the unemployed, and to establish certain minimum national standards with respect to eligibility, covered services, and duration of benefits.

We also believe that S. 951 could be improved in a number of other respects. In order to cover the large number of long-term unemployed who have already exhausted their unemployment benefits, the "reach-back" provision should be extended to include individuals who have received any form of unemployment compensation within the last two years.

In addition, the cost-sharing requirements should be reduced. As presently drafted, the states could impose a combination of premiums and deductibles totalling 18 percent of an individual's unemployment benefits. This places too great a burden on the unemployed, and would discourage participation in the program.

Furthermore, the formula for state matching funds should be modified to allow those states which have experienced the highest rates of unemployment to qualify, at least during an interim period, for 100 percent federal funding.

Finally, specific provisions should be added to provide for grants to public hospitals in areas of high unemployment, in order to insure that they will be able to continue to serve as the providers of last resort.

Senators Heinz and Specter have introduced another bill, S. 811, which would also establish a block grant program to enable the states to provide some health care protection for the unemployed. Again, we applaud the efforts of these Senators to address this important issue. This proposal, however, contains many of the same problems as S. 951. In addition, S. 811 would provide even less guidance to the states concerning the manner in which the funds may be used. And it does not establish any limits on permissible cost-sharing which may be imposed by the states on the unemployed. For these reasons, we believe that S. 811 is less desirable than S. 951.

Senators Riegle, Levin and Metzenbaum have introduced a bill, S. 307, which would adopt a slightly different approach towards providing health care protection for

the unemployment. We commend these Senators for moving expeditously earlier this year to propose a solution for this pressing national problem. We do have concerns about their proposal as well. In particular, we have reservations about the size of the premiums and copayments which would be required under the proposal.

In conclusion, Mr. Chairman, we emphasize our unequivocal opposition to various suggestions that a program for health care protection for the unemployed be linked with establishment of a "cap" on the amount of tax exempt contributions which an employer can make to an employee health care plan. These are two entirely different issues which should not be joined.

The proposals to place a "cap" on the amount of tax free employer health care contributions contain a number of serious defects, even when considered on their own merits. The establishment of such a "tax cap" would discriminate against older workers who require more medical care, and against employee groups in high cost areas of the country; discourage employees from joining HMOs; disrupt collective bargaining; and impose substantial new tax liability on millions of workers. Moreover, we believe a "tax cap" would have no effective impact on containing rising health costs, as some proponents maintain.

More importantly, however, we believe that Congress should not permit the adoption of a health care program for the unemployed to be held "hostage" to the "tax cap" proposals. There is an urgent need to do something <u>now</u> to provide health care protection for the unemployed. In light of the widespread support for such a program, it should be possible for Congress to act quickly to meet this pressing need. On the other hand, there is widespread opposition from business, provider groups and the insurance industry, as well as labor unions and consumer organizations, to the notion of placing an arbitrary cap on tax exempt employer health insurance contributions. Any attempt to inject this controversial issue into the discussion concerning health care

for the unemployed would simply throw a roadblock in the path of efforts to obtain speedy action to deal with this urgent national need.

We sadly recognize that there will continue to be large numbers of Americans with limited incomes in need of health care who will be ineligible for assistance from existing public and private programs, and even from the various programs described in the proposals currently pending before this Committee. Logic and experience dictates that over the long-run, only comprehensive national health insurance, with effective, built-in cost controls, will be the appropriate solution to these problems. As an intermediate range answer to part of the problem, however, the various proposals being considered by this Committee represent an important first step towards meeting the unmet health needs of the unemployed.

Mr. Chairman, we commend you and members of this Committee and other Senators for displaying leadership in this area. We urge you to consider the various suggestions set forth above as you continue in your efforts to develop a sound, balanced and effective program of health care for the unemployed.

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