S. HRG. 102-1037

STATE HEALTH CARE REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

JUNE 15, 1992

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STATE HEALTH CARE REFORM

MONDAY, JUNE 15, 1992

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

The hearing was convened, pursuant to notice, at 10:40 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: Senators Baucus, Pryor, Packwood, and Chafee.

[The press release announcing the hearing follows:]

[Press Release No. H–35, June 9, 1992]

HEARING ANNOUNCED ON STATE HEALTH CARE PLANS, SENATOR RIEGLE NOTES IMPORTANCE OF STATES' EXPERIENCE

WASHINGTON, DC—Senator Donald W. Riegle Jr., Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, Tuesday announced a hearing to examine various states' plans for enhancing access to health care and controlling health care costs.

The hearing will be at *10:30 a.m., Monday, June 15, 1992* in Room SD–215 of the Dirksen Senate Office Building.

The purpose of the hearing is to find out how states' proposals were developed, difficulties states face in implementing plans, and how the plans affect health care access, cost and quality.

Witnesses will include Governor Lawton Chiles of Florida and Governor John Waihee of Hawaii.

"I am holding this hearing on innovative programs that states are developing to reform their health care systems. State experience in this area is extremely helpful to the national debate on health care reform," Senator Riegle said.

"At the same time, states cannot alone solve the health care crisis in our Nation. Many states face barriers to moving forward on implementing innovative plans and ultimately, the Federal government must be involved to ensure that skyrocketing costs are controlled and basic coverage is guaranteed for every American."

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

Senator RIEGLE. The committee will come to order.

Let me welcome all those in attendance this morning and most especially our distinguished witnesses. We have two of our Nation's Governors here today. And we will be introducing them a little bit later.

Let me make some initial comments and then I am going to call on Senator Pryor.

Senator Leahy, we are going to be calling on you first. If you want to come up and take a seat, we would be pleased to have you do so now.

Let me say that today's hearing will focus on innovative programs that various states are developing to control health care costs within their States and to expand coverage to their uninsured citizens.

State experiences are a very important part of the national debate on health care reform. We know that States by themselves cannot fully solve the health care crisis in our Nation and, in fact, we need important reforms at the national level to help the States.

This hearing complements other hearings that Chairman Bentsen is holding to examine proposals to reform our health care system nationally.

Our health care system in our country is in a state of crisis. We spend more now than $800 billion a year on health care or about $2.2 billion a day.

Just a decade ago, a family's out-of-pocket costs were about $1,700 a year in the year 1980 to cover health care insurance. That had risen all the way up to $4,300 on average by 1991. And it is rising every single day.

At the same time, there are more than 35 million Americans who have no health insurance coverage whatsoever. So skyrocketing health care cost and the growing number of Americans with no health insurance are signs that our health care system must be reformed.

State officials, of course, see the crisis first hand and have direct experience in this area. States themselves are major purchasers of health care, primarily through the Medicaid program, but they also regulate insurance, they license health care professionals and institutions, they certainly allocate capital resources, and they deliver services.

In 1990, State and local government spending accounted for 13 percent of total national health care spending. Total real spending on Medicaid alone has increased from $27 billion in 1975 to almost $65 billion in 1990. And it continues to go up and up.

Medicaid is accounting for a rising percent of State budgets in the 1990's. And it is now in the double digits. At the same time, the percentage of uninsured people varies widely among States from an estimated percentage of a low of 8 percent across the board to as high as 26 percent in other States.

High health care costs and these urgent human needs within the limited State budgets create a tremendous force for reform and experimental ways for the States to try to cope with this situation. We will hear about some of those today.

We have some important examples from across the country of reform efforts various States are undertaking. So far this year alone, Florida, Minnesota, and Vermont have passed reform programs and more States are considering proposals.

Hawaii has had a comprehensive health plan in place since 1974. So they have a great length of experience. And they will share that with us today.

I am very pleased that the Governors, senators, and representatives of those States are with us to testify about their programs.

After hearing from them, we will hear from experts from the States of Washington, Massachusetts, and Oregon who will testify about activities going on in those States.

The lessons we learn from State experience will be critical in helping us to develop a consensus on national health care reform.

In this hearing, we will find out how State proposals were developed, the difficulties that States faced in implementing plans, and how the plans affect access, cost, and quality of care.

State and Federal Governments clearly need to work together on reforming our Nation's health care system both now and in the future, particularly, as Congress is moving forward on reaching a consensus on national health care reform, but more immediately, States face Federal barriers to implementing innovative State plans.

And we want to work with you. We want to work with the States to try to help solve that problem, and where waivers are needed and justified to see that they are given so that the States can move ahead to meet the problems that they are asked to deal with.

But I think at the same time it must be said that State initiatives, as important as they are, cannot be a substitute for broad, national reform.

Ultimately, it is the Federal Government that I think has to be involved to help make sure that skyrocketing costs are controlled and that basic coverage is guaranteed to every American.

[The prepared statement of Senator Donald W. Riegle, Jr. appears in the appendix.]

Senator RIEGLE. Senator Akaka who wanted to be here this morning to introduce his Governor asked that his statement be inserted for the record.

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

Senator RIEGLE. And I also have a statement from Senator Durenberger who very much wanted to be here this morning, but was unable to do so. We have a witness here from his State. And he asked that his statement also be made a part of the record.

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

Senator RIEGLE. Senator Pryor, let me call on you now.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Mr. Chairman, thank you for holding the hearing this morning.

We are so honored to have our former colleague, Governor Chiles, who graced the United States Senate for several years and now is back on the firing line again at the State level. As Governor of Florida, he is in a very, very strategic role.

And he has utilized that role, Mr. Chairman, as all of us know, in a very courageous way. His State is attempting, as are many others, very innovative ways to tackle the health care crisis that this committee is dealing with on an almost daily basis.

And Mr. Chairman, I want to say how proud I am that he is going to be with us today. Also, we are so pleased that Governor Waihee, the Governor of the beautiful State of Hawaii, is here with us this morning.

And we also look very much forward to hearing from our other impressive witnesses who will come before us and tell us about all

the existing health care reform initiatives that are going on out in the States.

Mr. Chairman, I have a longer statement I would like to insert in the record, if I may be permitted.

Senator RIEGLE. Without objection.

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

Senator PRYOR. And I would like to make only two or three very quick additional points. I think what the States are doing—unlike us I must admit—taking the bull by the horn. And they are going forward.

No longer can they afford the luxury of waiting for the Federal Government to do something because at the moment—and I hope it is only temporary and I think it is only temporary—at the moment, we find ourselves not being able to discover that consensus.

So the States are out here. And through leadership and courage and I must say some political risk, these Governors in many of the States are out there working on massive system-wide restructuring of these health programs.

And they are recognizing that these problems are much more than statistics, much more than percentages, that these numbers that show up on bars and graphs are, when you get right down to it, human beings.

Our Governors are dealing with these cases on a daily basis. They are the ones most actively involved in delivering these services and attempting to make these systems work.

I think that they have inspired I might say the Federal Government. I think the States are truly inspiring the Federal Government to do something. And I hope that we will take this wisdom and we will try even harder to find this consensus that the States are actually achieving.

And it is leaders like the Governor of Florida, like the Governor of Hawaii, like the National Governors' Association that are really trying to cut through this Federal bureaucracy and to say to us in Washington, "Look, we have a problem. And we cannot wait any longer. We have got to deal with it now."

Finally, Mr. Chairman, our colleague, Senator Leahy of Vermont, probably knows more about what we ought to start doing on the Federal level to provide the avenue for the States to do more. Senator Leahy has long labored in this venue.

I just want to say a personal word about Senator Leahy. He has taken this on almost as a cause unto himself. He has been for some time almost a voice out there in the wilderness, saying what we should do as a Federal Government to enable the State governments to do more.

I applaud him, Mr. Chairman. And I am glad that he is going to be here with us.

And I am proud to be associated with him in some legislation that we are going to introduce a little later together.

And I think that several of our colleagues on this committee are going to join us. We hope so. He has been a real leader.

Mr. Chairman, thank you for holding the hearing, once again. I look forward to the hearing this morning.

Senator RIEGLE. Well, thank you, Senator Pryor. Serving as you did as the Governor of your State, you certainly bring the knowledge from both prospectives that our Governors are bringing us, as does former Governor Chafee.

Senator CHAFEE.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman.

I will put in a statement.

I am very interested in what the States are doing about spiralling health care expenditures. The Republican Health Care Task Force bill we introduced last November contains a number of cost containment provisions, the need to control health care costs is one of the issues that we have been discussing in our bipartisan meetings on health care reform.

So I look forward to the upcoming testimony.

Thank you, Mr. Chairman.

Senator RIEGLE. Very good. We will make the statement a part of the record.

[The prepared statement of Senator John H. Chafee appears in the appendix.]

Senator RIEGLE. Senator Leahy, we are very pleased to have you here today. And I, too, want to join Senator Pryor in commending you for your leadership.

And we are very interested to hear about the experience in Vermont.

And we will make your full statement a part of the record.

[The prepared statement of Senator Patrick J. Leahy appears in the appendix.]

Senator RIEGLE. And we would like your comments now.

STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM VERMONT

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

And I appreciate the opportunity to come before you. I know that you have a very busy agenda. And I appreciate the time that you have given me.

I want to tell you about what Vermont has done. It is really an ambitious new law to bring health care to all Vermonters. It can also set an example for much of the rest of the country.

Senator Riegle, during the development of the HealthAmerica legislation, I know you established a very close and productive working relationship with the National Governors' Association.

I have heard from many of them. I might say they appreciate your sensitivity to the Governors' concerns. They are really on the front line on this across the Nation.

And I wanted to describe legislation that Senator Pryor and I are developing to help Vermont and other States put their comprehensive reform plans into action.

And I appreciate, Senator Pryor, the very kind words you said. I have enjoyed working with you, especially with your perspective as the Chair of the very important Aging Committee, and also as a former Governor.

All of us know that our current health care system needs fundamental change. There is nobody who will stand up in any hearing that I have been to who will defend it as it now exists.

We have skyrocketing costs that are hurting families. They are ruining businesses. They are leaving millions of Americans without adequate care.

I recently talked with a woman in Vermont. She has worked all her life. She is married, has three lovely children, but faced losing her home, filing for bankruptcy, losing the business that she and her husband had started because she had no health insurance to pay her enormous hospital bills.

I heard from an engineer in Vermont who lost his job, then lost his unemployment benefits, and then he almost lost his home.

Well, these are real people. They are not statistics. And they are people who are living in fear. They are not the people who live in fear in a crime-ridden area because in Vermont we have about the lowest crime rate in the country, but they live in fear as generations of proud Vermonters. They live in fear that they cannot pay their health bills.

These are people that traditionally cared for their own families. Now, they are finding that a single illness can wipe out all the years of hard work, all their savings, the equity they put into their home or their business, everything they have worked their whole life for can just be wiped out.

That is fear. It is not a fear that goes away because you put in a burglar alarm system or lock the door or anything else. It is there every single day.

And I think we need a comprehensive national solution to this crisis. I am working, as you are, Mr. Chairman, with the Majority leader to build consensus on a comprehensive health care reform bill that we can move this year. And he has my thanks for carrying on this herculean task.

Our efforts are strengthened by the Nation's Governors. They have been extremely strong voices in continuing to push for comprehensive health care reform both at the national and State levels.

We are going to hear from two today, Governor Chiles who we all know and served with in respect and Governor Waihee of Hawaii who has in his State an extraordinary health system.

They are going to tell us how they have been able to break the health care deadlock and build consensus around programs that are providing affordable care to the people in their States.

Now, in my own State of Vermont, the momentum for health care reform has been building for a number of years. Last year, the Vermont Legislature passed the strongest small group insurance market reform law in the country. The law takes effect this July.

It is going to get insurance companies back in the business of managing risk and health costs and makes health insurance available to Vermonters who have been shut out.

The law bans medical underwriting and other discriminatory rating practices, and requires the use of community rating.

This year, under the strong leadership of Governor Dean, who incidentally is the only physician Governor in the country, Vermont enacted one of the most sweeping universal access plans yet.

The law passed with overwhelming support from both houses of the Vermont Legislature. And many Statewide organizations, including the Vermont State Medical Society, backed the plan.

Under our law, we commit the State to several key principles: global budgeting, consolidated health care regulation and administration, and the design of a universal access system.

It is long on Vermont good common sense. It emphasizes preventive and primary care, something we do not have enough of. It sets a fixed, total health care budget. It does it right up front so that we can control costs.

And I ask, Mr. Chairman, unanimous consent that a summary of that law be placed in the record.

Senator RIEGLE. Without objection. So ordered.

[The prepared summary of the law submitted by Senator Patrick Leahy appears in the appendix.]

Senator PRYOR. And we also have a newly created State health care authority to set the budget. It also is going to prepare detailed designs for both a single-payer and a tightly regulated multi-payer system.

Now, we will have public hearings around our State. We will learn about and comment on the different payment systems before the Legislature begins its debate on which one is right for Vermont.

And when the plan is in place by the end of 1994, all Vermonters will have access to affordable health care, all Vermonters.

We take the first step toward universal access this July with a comprehensive health insurance program that provides coverage for children up to age 18 living in families with incomes at or below 225 percent of poverty.

It means no longer having to make a choice between whether you are going to feed your children or whether you are going to keep your children healthy. Parents will be able to do what parents are supposed to do, do both.

What makes the Vermont approach unique is that it leads with cost containment. The Governor argued successfully for a plan that controls cost first before we put more money into our health care system. So whatever system we have in 1994, the State is going to implement global budgeting.

Now, there are many tough decisions ahead for us. And we are a State of 570,000 people. We are not a wealthy State, but we are committed to having health care for every single person in our State and we are going to do it. And we are doing it with a realistic plan that makes it work.

If we are going to succeed, Vermont and States like Florida, Hawaii, and all the others who want to do this, they are going to need Federal support and involvement. That is where the legislation I introduced last year, State Care, comes in, S. 1972.

The idea for State Care came from a town meeting we held in Vermont where somebody wondered why States could not come up with their own way for covering everybody and controlling costs.

Our purpose in State Care is to encourage State-based comprehensive reforms by cutting Federal red tape and giving States the waivers from Federal requirements they need to reach their goals.

And earlier this year, my good friend Dave Pryor, joined me in this legislation. His knowledge I must say—Senator Pryor's knowledge and judgment have been invaluable. We worked with a lot of different groups to refine and strengthen the legislation.

I want to recognize the constructive suggestions of Chairman Bentsen and his staff and of yours, Mr. Chairman. I want to work together with all of you because later this summer, Senator Pryor and I will introduce new legislation that reflects the negotiations of this year.

Our bill will allow up to 10 States to serve as demonstration sites. It will give them the flexibility to design the health care delivery system that works best for them.

They will have to put together truly comprehensive plans that assure health coverage to all residents and control overall health care costs. And it will require States to achieve a significant reduction in their health care inflation rate.

A Federal commission will approve, monitor, and evaluate State reform initiatives. The waiver process for Medicaid and Medicare will be streamlined and expanded to allow greater experimentation with these programs.

The States have to continue to provide Medicare services to the Medicare population and to provide mandated Medicaid benefits to Medicaid recipients.

Our legislation also will grant a limited exemption from the ERISA preemption that now greatly hinders most State access and cost containment strategies. Senator Pryor and I recognize the concern any type of ERISA waiver raises, but I want to emphasize that exemptions will only be granted to the limited number of States that have enacted comprehensive reform initiatives.

In closing, I want to thank Senator Pryor, other members of this committee, Governors Chiles and Waihee, and the National Governors' Association for their hard work on this legislation.

We see pioneering efforts in Vermont and Florida and Hawaii and other States. I think they can lend the urgency needed for the kind of Federal legislation, Mr. Chairman, that you spoke of in your opening statement.

You know and I know that eventually this is going to be there for all Americans. But I know that there was a time in this country when 28 States had child labor laws before Congress passed child labor legislation.

Twenty-four States had some type of Social Security in 1935. Presidential leadership forced the Federal Government to have it for everybody.

We are seeing the same thing happening with health care. And what a better country it will be when nobody has to fear whether they will be able to afford health care or not.

Mr. Chairman, I thank you very much.

Senator RIEGLE. Thank you very much, Senator Leahy.

I am going to pose one question in a moment. We have been joined by Senator Baucus.

Senator Baucus, did you have an opening comment that you want to make?

Senator BAUCUS. No.

Senator RIEGLE. Very good.

Senator Leahy, I want to underscore I think a point that you were just making and that is you feel that waivers ought to be available to States, but only if they have developed a comprehensive plan.

And I assume the comprehensive plan should include cost control on the one hand and a plan to guarantee access on the other hand, that these two components have to be part of the plan.

Senator LEAHY. I think you have to have that. I think any plan falls under its own weight, if you do not have real cost control and if it is not available comprehensively. If it is not, I do not think we should grant waivers.

Senator RIEGLE. Now next, I noticed in Vermont, the way Vermont is doing this is that it is phasing in first the cost control mechanisms and then has set a time table to have a plan for access where everybody then will come in and receive coverage. So the 570,000 people of your State, regardless of circumstances, will presumably be covered.

Can you elaborate a bit on the one-two step approach and why cost controls were being done first and the access is coming later on down the line?

Senator LEAHY. We are a cautious State, known for its frugality. There is no way our legislature in a small State like ours could just simply write a bill and say everybody is going to be covered, without knowing what it is going to cost.

It would not have passed. Vermonters would have been afraid even to accept it. We also know though with the pressure of the availability of universal coverage, that is also going to create the momentum for the kind of cost control that all of us are going to have to do in health care to make it work.

So being a small State as we are, in some ways it was both more difficult and easier, more difficult because of a small base of money, but easier because everybody knows everybody and you can actually make those kinds of cost control steps.

That there may be some comparison there to the State of Hawaii, we are going to be very interested to look at their experience just a little bit later this morning.

Senator RIEGLE. Thank you very much.

Senator Pryor.

Senator PRYOR. I think I just have one question, Senator Leahy, and that relates to cost containment. On the Federal level, do you think there is something that we can learn on the Federal level from States like Vermont as to what you have done in the field of cost containment?

Senator LEAHY. I think there is, Senator. And I think we have to because at the rate we are going, by the end of this century, we are going to be spending one out of every three Federal dollars on health care. There is no industrialized Nation in the world that can exist that way.

We cannot. There is no other country that could. We have got to learn how to have real cost control, cost containment in health care or our budget and in some ways our government collapses on its own weight.

Senator PRYOR. Thank you.

Senator RIEGLE. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator, when you say you are going to provide health care, who decides what that entails? In other words, who sets up the package?

Senator LEAHY. The State will do that. That is one of the reasons we are putting together in our own State commission that will define both universality and what cost controls are.

Senator CHAFEE. But who decides what the benefits are going to be? Would that be set by—somebody has to set——

Senator LEAHY. That is what I am saying.

Senator CHAFEE. What the minimum benefits are.

Senator LEAHY. That is what I mean by in Vermont, the health commission would do it, the legislature will vote to agree to that, and that package will be determined by them.

Senator CHAFEE. I see. If you are like most States, you have certain mandated State benefits now which probably would have to be overridden by this package.

Senator LEAHY. Or include them. One of the things we have done this year is to expand the Dr. Dynasaur program to make sure that up to 18, poor children up to 18 are given certain basic care. A lot of that, of course, is preventive care.

And what we are finding, the obvious thing I think everyone of us as a parent knows is that this preventive care can save a great deal of money in the long run.

Unfortunately, for a lot of people, it has not been available either because they could not afford it, there was not the educational component available, or whatever else.

Just like the WIC Program, again, we as parents know good nutrition is good for our children, but sometimes it is not available to them.

Senator CHAFEE. Under your cost controls, do you address the issue of medical liability insurance reform, do you know?

Senator LEAHY. Under the State Care bill Senator Pryor and I are working on, States can include malpractice reform. Under the package we have in the Vermont Legislature, all medical malpractice claims will be reviewed by an arbitration panel upon the effective date of universal access.

Senator CHAFEE. It can be.

Senator LEAHY. Yes. It is not mandated in our State Care bill, but it can be included.

Senator CHAFEE. I would be interested in what that proposal is if you could——

Senator LEAHY. Could I make one suggestion on the liability issue? I know this comes up in every single discussion. But a word should go out to medical associations nationwide that people might be more willing to put some limitation on malpractice suits and so forth if they had the confidence in medical associations themselves to do the kind of policing necessary.

It is very disturbing to me as a citizen when I read articles about physicians who are sued for malpractice or in some cases even prosecuted for criminal malpractice and you find that what they have been doing has been going on for 5, 10, or 15 years in hospitals where a lot of the other medical personnel were well aware of it and nobody blew the whistle.

I have seen cases of people who, after having botched heart operations or other serious operations, finally get sued and then it turns out that there have been a whole series of these.

I think—and this has nothing to do with the legislation we have—certainly the question of excess judgments or malpractice insurance is a legitimate one, but the medical societies themselves are going to have to do a better job of policing themselves just as any professional society that gets specific benefits for their people, whether it is in the legal business, banking, medical, aeronautics.

I mean, with any one of these things, they have to be willing to say, "Look, this person is a drug addict. This person is incompetent. This person is an alcoholic or whatever these other problems are. And we are blowing the whistle on them right now."

Senator CHAFEE. Our legislation provides that—and I'd be interested to know what you think of this—punitive damages go not to the plaintiff but to a board to reeducate physicians and to police the very groups that you were discussing.

Senator LEAHY. Well, the medical associations given a particular position they have in society, economic and otherwise, ought to be doing that anyway.

If I was the person who came in and had a botched operation which may have left me paralyzed or blind or something like that and then I find that the physician had botched several others like that and had not done anything, it is going to be small consolation to me to know that the punitive damages or whatever else I might have received are not going to go to me, they are going to go to some board to do something they should have done anyway.

Senator CHAFEE. No, no, no. The compensatory damages would go to you. We are talking about punitive damages.

Senator LEAHY. Punitive damages, of course, would go only if you have gross or virtually willful negligence. If you have that, I think you are going to find most plaintiffs are going to want almost vengeance in those cases.

Whether there could be a provision to set up for reeducation or something, sure, I am all in favor of that. But I am not too eager if you have willful or gross negligence to say that somebody cannot be compensated for that just because they have, in part, been compensated by other damages. I know the anger that would be felt by such a patient.

Senator CHAFEE. Thank you very much.

Senator RIEGLE. Thank you.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator RIEGLE. I might say on that issue, I think we have seen other areas. We have certainly seen it in the banking community with respect to problems that have arisen over the years in both the banking and the savings and loan industry where there were people who went way outside the lines on doing certain things.

But for a long period of time, the broad associations of those practitioners who were very much at risk of the conduct of some, they did not blow the whistle either.

I think there is an obligation here. I mean, health care is one area, but I think when bad practice is going on, those that see it have to help stop it especially when the effect of it is likely to spill over on them as well.

Senator LEAHY. If I may make one possible suggestion. I think you have to go slowly on this because a lot of these are voluntary organizations, but we are paying more attention now to directors liabilities for malfeasance by corporations or other organizations.

Maybe we have got to say there has to be some further responsibility on the part of the people who serve on the boards, everything from the examining boards to the professional conduct boards, that it is not simply a position that one gets in the Bar, the medical society, or whatever, as a kind of honorarium.

Senator RIEGLE. Right.

Senator LEAHY. There ought to be more responsibility.

Senator RIEGLE. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

I think your bill is a good idea. I think it is critical at this point that States be encouraged to experiment, if you will, to try to find ways to solve this problem.

As you well know, that is what happened in Canada. That is, the Canadian health care system was first enacted in the Province of Saskatchewan. I think it was in the late 1960's.

And the rest of Canada liked the Saskatchewan experience so much that the other provinces and the Federal Government of Canada essentially adopted the Saskatchewan approach.

I think that we eventually in this country will enact very far-reaching health care reform in this country, but I also think that it will be the component of several State plans or several State experiences.

And we will hopefully, as Canada did, enact the one in this country that seems to have worked best in some, one, two, or three States in this country.

That is not to say we will enact the Canadian system, but it is to say that we will probably enact health care reform that has some of the components of the Canadian system.

I do not know if it is going to be a single payer or not. In that vein, I would like to ask you and will ask you the Vermonters' views of the Canadian health care plan?

And as Vermont enacted its legislation, what aspects of the Canadian system were popular and what not and so forth?

Senator LEAHY. Well, it is interesting because, of course, we border Canada. And in the northern part of our State, there is a lot of interaction back and forth between Canada.

A lot of people are of Canadian descent. My wife is a first generation Franco American. Her family lives in the Province of Quebec.

Now, we hear all the bad things about the Canadian system as well as the good things, but one thing we hear consistently, is that nobody fears the unavailability of health care.

They may find some of the inconveniences, it may not be exactly on the schedule they would like, they may have to wait in line for some things, but they know it is going to be available.

They know when a child has an earache, they do not have to make up their minds, "Well, if this is not serious, I am risking this month's rent money by taking the child to the doctor. But if it is serious, the child could lose his or her hearing if I do not go."

They do not have those kind of questions that the average Vermonter has because it is always available.

So sure, there are some aspects of it they do not like; aspects they do. The one thing though we always hear is there is no fear.

What you said about the States is so true. I mean, you come from a State which is one of the largest States in the country geographically, but has less than a million people. I mean, we think of ourselves as being rural in Vermont.

If you were to define some of the rural areas, your needs and the way you are going to provide a health care system may be a lot different from a city that has very, very, large cities.

But wouldn't it be great if a few States like Montana and Vermont and Hawaii and Florida could demonstrate how they take care of the different needs because each of those four States I mentioned will have extremely different needs. We could get out of that a pattern that we can adopt for the rest of the country.

And I agree with you. That is where ultimately the emphasis is going to come from.

Senator BAUCUS. I appreciate that. And I also strongly encourage Vermont to bite the bullet the next couple of years with very meaningful cost controls.

Senator LEAHY. We are going to have to.

Senator BAUCUS. And with absolute versatility and frankly do what we all know has got to be done anyway. Thank you.

Senator LEAHY. Thank you.

Mr. Chairman, I really thank you for the opportunity. And I appreciate the concern all four of the members here have expressed in health care.

Senator RIEGLE. Thank you, Senator Leahy. We appreciate your testimony and your leadership.

Let me now invite Governor Chiles of Florida up and Senator Graham, former Governor Graham. We are delighted to have you both.

Senator Graham, let me invite you to make whatever introductory comments you would like to make at this time.

STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator GRAHAM. Thank you, Mr. Chairman.

It is my pleasure today to introduce our former colleague and friend, Governor Lawton Chiles.

In the Senate and now as Governor, Lawton Chiles has distinguished himself in the State of Florida in the area of health care.

The Florida Legislature recently passed a State health reform plan which seeks to guarantee access to quality health care by December 31, 1994 through a multi-faceted approach.

Governor Chiles' interest and fortitude made this proposal possible. An important component of this proposal which Governor Chiles will discuss in his statement is a State Medicaid Buy-In Program.

I believe that a Medicaid Buy-In represents an appropriate start for a future comprehensive reform effort.

I would like to point out for the members of the committee that in 1988 as a candidate for President of the United States, President Bush advocated a Medicaid Buy-In as an initial step towards a national health care program.

Last year, I introduced a Medicaid Buy-In measure, S. 1211. The bill is not a long-term solution to our health care crisis. It does, however, expand the existing program through cost sharing for those who can afford it and, as the Florida experience will indicate, will be an important beginning toward that solution.

The Florida plan also demonstrates leadership by example. The State is using its influence to cause other institutions within Florida to adopt effective programs.

As an example, effective July 1, 1994, all contractors and subcontractors with State agencies must assure that their own employees have health care insurance.

Mr. Chairman, until Congress can agree on a Federal health care plan, we should encourage States to enact and implement various health care reform approaches.

That is why I am a cosponsor of Senator Leahy's bill to promote State health care reform efforts.

We are in a period of reinvigorated federalism. If one level of government or one branch of government is grid-locked, then others can respond. In this case, State governments are coming forward with comprehensive health care programs.

States can also use the concept of federalism for innovative and experimental programs. In the past, States have helped our country develop such concepts as universal suffrage, workers' compensation, and Social Security, all initiated from State-level efforts.

We as politicians need to step forward against those who will resist these efforts out of the attempt to defend entrenched status quo rather than to support efforts such as Senator Leahy's which allows for innovation and experimentation.

I look forward to working with Senator Leahy, Governor Chiles, other Governors, and members of this committee in helping Florida and other States receive the necessary waivers to move forward with crucial and innovative health care reform.

Mr. Chairman, it is my privilege to introduce our friend and former colleague, Governor Lawton Chiles.

Senator RIEGLE. Thank you very much, Senator Graham. And we appreciate you coming this morning to introduce him and to make those comments and for your leadership as well in the health care area.

Let me just say to Governor Chiles, when you left the Senate, it was a source of heartache to many of us because you were so much esteemed by your colleagues on both sides of the aisle.

And so we have been following with great interest and excitement your Governorship down there.

We know there are some very tough economic problems throughout the country and in your State, but your innovative leadership is one of the bright spots across the country.

And so we are very interested in what you have to tell us today as to what you are doing in the health area.

We will make your full statement a part of the record. And we welcome your comments now.

[The prepared statement of Governor Lawton Chiles appears in the appendix.]

Senator CHAFEE. I will make that bipartisan. We miss you. However, you have a wonderful replacement.

STATEMENT OF HON. LAWTON CHILES, GOVERNOR OF THE STATE OF FLORIDA, TALLAHASSEE

Governor CHILES. Thank you very much, Mr. Chairman, Senator Chafee, Senator Pryor, and Senator Baucus.

I am delighted to be here today and to follow Senator Leahy who is certainly carrying out a great mission we think for pursuing flexibility for State-based health care reform.

I appreciate very much the kind remarks of Senator Graham who had the opportunity to be a Governor of Florida and understands the challenges of the job.

It is an exciting time in the States. I am reaping the results of some of the things that perhaps I helped to invoke upon the States when I was up here.

Thank you for inviting me today to speak about our Nation's pressing need for health care reform and about the early progress that we have made in Florida in attempting to work out a health care solution for our residents.

I want to begin, Mr. Chairman, by stressing that I share your feelings that national health care reform has become an absolutely essential part of the American agenda. The longer we delay, the more difficult it will be to come up with a solution.

While we very much support waivers for States as envisioned by the Leahy-Pryor bill, they will not suffice for having a national solution.

Nothing we will do in the States will totally suffice. It would be nice to say that it would.

I called upon the Congress and the Administration to move quickly to enact comprehensive health care legislation when the National Governors' Association met in Seattle last summer.

At the time, Governors stated that we would prefer a national solution to our health care cost and access problems, but also the States can no longer wait for the Federal Government to act.

First, we will never resolve our National health care crisis without a national plan with national goals, standards, and objectives. But in the absence of that, we need to move ahead.

And for some of our citizens, it is a matter of quality of life. For too many more, it is a matter of life itself.

I think it is important that Congress and the Administration recognize the significant health care reforms being implemented by the States.

You are going to hear from Governor Waihee of Hawaii. Hawaii has taken a leadership role among all of the States in putting together the first comprehensive health care plan.

Now, we are seeing a number of other States, including Florida following their lead. These reforms demonstrate our willingness to tackle the twin problems of rapidly rising costs and decreasing access to care.

For this reason, we need a bill that will give 10 States the flexibility to develop different approaches to health care reform. Any comprehensive reform proposal passed by Congress should include a provision similar to the Leahy-Pryor bill to allow States pursuing comprehensive approaches to continue down that path.

In the event a consensus cannot be reached on national reform this year, certainly flexibility should be given to States that are ready to pursue their own reforms.

I compliment in addition to my colleague from Hawaii, Governor Waihee, the Governors of Minnesota, Oregon, and Vermont for providing national leadership in this area.

As you know, Hawaii is the first State to have virtually universal access. And since the mid-1970's, Hawaii has had that program in place.

This commitment to universal coverage is reflected in their low infant mortality rates which we jealously wish we had in Florida and the above-average health status of their residents. Also, their health costs have not been rising to the same extent that we are experiencing in other States.

Now, Minnesota and Vermont have taken the bull by the horns and moved ahead to make sure that their residents have access to health care.

Minnesota has done this through its Health-Right program. Vermont has created a new health care authority to develop its plan.

Finally, Oregon has proposed an innovative approach to extend Medicaid coverage to more of its low-income, uninsured residents.

In Florida, we have 2.5 million uninsured residents and we are taking a different approach. We know that most of our uninsured residents are either workers or family members of those workers.

We know most Floridians prefer a largely private, employer-sponsored system of health insurance coverage.

So instead of beginning by committing State government to covering all Floridians, we have issued a challenge to the private sector to try to solve the problem themselves.

In March, I signed into law Florida's Health Care Reform Act of 1992. And I will submit a summary of that for the record if you will permit, Mr. Chairman.

Senator RIEGLE. Thank you. Without objection. We will make it part of the record.

[The text of the Florida Health Plan, Health Care Reform Act of 1992, submitted by Governor Lawton Chiles, appears in the appendix.]

Governor CHILES. This legislation includes our comprehensive health care reform proposals, the Florida Health Plan as well as a set of health insurance reforms targeted at the small employer market.

Our goal is to ensure that all Floridians have access to a basic health care benefit package by December 31, 1994. Ultimately, we foresee a system in which every Floridian will have a family doctor who serves as a gatekeeper to a managed care system.

Beginning July 1 and running through the end of 1994, we will operate a voluntary private sector health care coverage and cost containment program. The new Agency for Health Care Administration will develop targets to measure the program's success.

It comes as no surprise to members of the subcommittee that the passage of this legislation required a level of compromise and cooperation that we do not typically see.

I believe that it attests to the growing sense of urgency felt by all who are concerned with health care and that includes just about everyone.

The legislation enjoyed bipartisan support in both houses of the State, a total of only two negative votes. It also gained the support of a wide range of provider, employer, and consumer groups.

I had no illusion about our initial success in passing this legislation. I feel a little bit like a boxer who has won the first round, but knows that there are 11 or 14 rounds to go. There are bound to be plenty of punches that it will take.

We in state government are go to be doing our part to help the voluntary program work. We are reforming the small group insurance markets. We are including a Medicaid Buy-In program. We are expanding successful programs for the insured.

Our small business reforms include: eliminating some of the State benefit mandates, creating basic and standard benefit plans; requiring insurers to guarantee issuance of plans; to guarantee the issuance of plans and prohibiting certain underwriting practices; implementing a 12-month limit on exclusions due to pre-existing conditions; eliminating denials and non-renewals on small employer plans because of the health status, claims experience, occupation, or geographic limitation; and implementing restrictions on premium increases.

We are looking at ways to expand the Florida Health Access Program for small business employees and their families by developing a strategy to decrease the current level of premium subsidies, improve the group's negotiating and purchasing power, and redefine the use of managed care plans.

The pooled purchasing cooperative for private sector employers is going to expand its work with private business coalitions to get maximum benefit from each health care dollar.

Other parts of the Florida Health Plan address additional problems in the current system. The Florida Health Services Corps will trade State-funded scholarship assistance for students in certain health professions in return for a commitment to practice in medically under served areas.

In addition, I signed the Patient Self-Referral Act this year that according to Federal guidelines specifies the narrow conditions under which physicians can refer their patients to facilities in which they have invested.

Mr. Chairman, this is I believe the first State law which puts a lid on how we are going to allow physicians to refer. And in that law, we have caps on fees as well. This will save an estimated $200 million annually in Florida.

We must do even more. Increasing health care costs pose a serious threat to fully insuring our population and the affordability of even basic health care.

We believe that insuring all of our citizens is that first step. In other words, until we provide that access, we are not going to be able to totally control the other costs.

At the same time, the public and private sectors must mount an aggressive campaign to curb health care cost increases.

Florida is going to pursue a number of strategies including: establishing Statewide global expenditure limits; instituting tighter

market entry controls; promoting the use of managed care; controlling the spread of high-tech services; enacting additional regulatory reforms to simplify billing, reduce insurance overhead costs, and maximize the purchasing power of third-parties; implementing practice parameters to ensure the proper use of services; and assessing further medical malpractice reforms to reduce the insidious effects of defensive medicine.

I am a great believer in the free market and the use of incentives over mandates. But if we are to provide those incentives, we need your help to provide the additional flexibility.

I would like to submit a waiver summary for the record which specifies what we are seeking in detail.

Senator RIEGLE. We will make that a part of the record.

[The "Federal-State Health Care Issues, Florida's Flexibility Proposal," submitted by Governor Lawton Chiles, appears in the appendix.]

Governor CHILES. Thank you, sir.

We are designing a Medicaid Buy-In program for people with incomes up to 250 percent of the poverty level.

To implement our buy-in program, we need Congress to remove the restrictions that tie Medicaid to other Federal programs like SSI and AFDC.

In other words, Mr. Chairman, we need to separate the health from welfare.

If you will remember when the Congress allowed States to provide prenatal care and go above the poverty guidelines, you saw many States opt to provide that service, including Florida.

We also need Federal matching funds to help cover working people with incomes too high to qualify under current Medicaid rules, but too low to purchase private health insurance without some government subsidy.

The 2.5 million people uninsured in our State are basically working populations. They are the ones that, with our Medicaid buy in program, we think we could pick up at a smaller cost than any of the national plans that anybody has floated.

We need Congress to allow us to implement several other administrative efficiencies that will enhance our ability to serve Floridians and save Federal and State dollars: successfully tested home and community-based services for both developmentally disabled and the elderly; expanding managed care programs; and developing a system of accountability that avoids the nitpicking from certain Federal audits and documentary requirements.

Mr. Chairman, many of these waivers have been granted in one or more States. Within 2 or 3 years, we must go through the same process to try to extend that waiver. It is time consuming. We know these programs work.

Once one State has tried them and we know that they work, we ought to be able to say, "There is a blanket waiver for this program." Do not make us go through all of the paper work, cost, and expense of having to go through this again and again.

With these government supports and others, it is our sincere hope that the private, voluntary phase of the Florida Health Care Plan will achieve the goal of access to all Floridians by 1994.

Should the goal not be reached, we are moving full speed ahead with planning and developing activities to support a second phase. This will involve either a pay or play system or perhaps a single-payer concept if intervention is required.

So we hope it can be done voluntarily by December 1994. If it is not, we will have a plan ready to implement of how we will go into a mandatory phase.

Of course, to implement a play or pay, we need an amendment to ERISA. We understand there are many groups, including labor and large corporations, who want to avoid having to negotiate different insurance benefits in every State. But we feel there is room for compromise so that Florida can mandate a basic benefit package.

We clearly need the help of Congress to fully implement these reforms, but we are moving ahead as fast as we possibly can without it.

Florida along with Hawaii, Minnesota, Oregon, and Vermont have clearly not waited for a Federal mandate to move ahead. We remain ready to work with you. But with your help, the fourth largest State in the country is willing to try to extend the right to health care to its uninjured residents.

Senator Leahy talks about his State with 570,000 uninsured people. In Florida, we have a Vermont that moves into Florida every 2 years.

So we have 300,000 new people that move to Florida every year. So you can see the scope of our problem is a little bit magnified.

There is no easy solution, no single solution. A number of different steps are required. But the last point I will make is, as you all move ahead with your National solution which we know you will do, please do not have it be a totally top-down solution that locks in every State and says we all must do it one way.

We did that with Medicaid. We have done that with Medicare. That is why we are up here begging you for waivers.

That is why every State must have a role. Allow us the flexibility, require the bottom line accountability, require that we must meet certain goals, but allow Hawaii to do it in one way and Florida and Vermont to do it a way that will meet their needs. If we do not do that, we will not really have a real solution at all.

Again, I think the benefit of allowing 10 States to go forward now is to give us those laboratories of reform out there that you will be able to look at. You can see what parts of those programs every State should have and what other parts are truly those that the States should be allowed to do in different ways.

That experimentation I think will be very valuable to you in coming up with a national bill.

Senator CHAFEE. Mr. Chairman.

Senator RIEGLE. Yes.

Senator CHAFEE. Regrettably, I have to leave, but I just want to thank Governor Chiles for his testimony and also stress the importance of the point he is making about the States being laboratories, places where we can see what works.

Could I just ask one question?

Senator RIEGLE. Sure.

Senator CHAFEE. Twice you emphasized managed care. Did you have on your books, Governor, any so-called anti-managed care statutes?

In other words, that would prevent insurance companies from listing preferred providers and so forth. Are you familiar with that?

Governor CHILES. I do not think——

Senator CHAFEE. Some States have what you might call anti-managed care.

Governor CHILES. No. We do not have that.

Senator CHAFEE. And the insurance companies could not say that you have got to go to physician A, B, C, or to hospital X, Y, Z.

Governor CHILES. The whole thrust of our new plan is to drive people towards managed care. We believe without managed care—unless we can move away from expensive fee-for-service—we will never control these costs.

We are requiring companies doing business with the State to insure their employees by July 1994. We know that those programs are going to be basically managed care programs.

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

Senator RIEGLE. Thank you, Senator Chafee.

Governor Chiles, first of all, I appreciate your leadership on this issue and what you are doing in Florida and what you have come to tell us today.

Would you for the record, tell us what the experience has been in terms of the increase in your Medicaid costs in Florida? I mean, what does that profile look like over the last——

Governor CHILES. A 365 percent increase in the last 10 years.

Senator RIEGLE. Three hundred and 65 percent.

Governor CHILES. Three hundred and 65 percent.

Senator RIEGLE. A 365 percent increase in the last decade.

Governor CHILES. Yes, sir. Every new dollar that we received in Florida on the basis of the growth of our general revenue was eaten up by Florida's share of the Medicaid program in this last year.

So we had no money left for education; no money left for public safety, prisons, law enforcement; no money left for the environment, parks, or anything else. All of those new dollars are eaten up.

That is why we are now having to raise taxes as I am proposing to the State Legislature.

We know that unless we can get universal access and unless we can move to preventive measures, like managed care and going into prenatal care, we will ever control costs.

The Federal share of that cost was I think roughly $800 million last year. So it is not just taking the State's money.

Senator RIEGLE. I understand.

Governor CHILES. It is part of that Federal deficit that you are groping with.

Senator RIEGLE. That is exactly right. Would it be fair to say that of the large items in your budget—and Medicaid would be a very huge item in your budget. Would this be the item of your budget that has had the most rapid cost increase?

Governor CHILES. It is the Pac Man that is eating up everything else. AFDC has increased 150 percent. Our cost for prisons and law enforcement increased 150 percent.

Our cost for education with 100,000 new students a year only grew 56 percent during that time. I mean, it is still too high, but it was only 56 percent.

Senator RIEGLE. And that is why this then becomes an urgent issue both from the point of view of the public health, but also just the financial soundness and stability of the State.

Governor CHILES. Absolutely. The 2.5 million that are uninsured, Mr. Chairman, are getting medical coverage.

They get it when they go to emergency rooms. They get it after they become so sick that, when they go, the coverage costs more.

The cost of private insurance in Florida increased 17 percent last year. I believe it was about as high as any State in the Nation.

So the uninsured 2.5 million Floridians are burdening every sector of our State because all of us that have private insurance are paying for it.

Senator RIEGLE. So the point is I think we are going to pay these costs one way or the other.

Governor CHILES. We are paying. We can wait and allow all these health problems to build up in people and then pay the high cost to try to fix those health problems with all the sadness and the loss of life and everything else.

Or we can control this system and spend less money on the front end and get decent preventive care in place and actually come out ahead of where we are today.

The result will be more healthy people. We will have a better work force. We will have better education. We are finally realizing in Florida with all of our attention to education, we cannot educate a child who is not healthy.

Senator RIEGLE. Right.

Governor CHILES. If you want to deal with drop-outs, we now figure that prenatal care is the most important program rather than a drop-out prevention program at 14 or 16.

Senator RIEGLE. Well, Senator Leahy said, too, if you can take that fear factor away, when you got parents who are laying awake at night, a single parent in many cases, is frightened about a child's health and not having any coverage and worried about whether they can pay the health bills, society should not live that way.

No other major country today is living with that anxiety. They have all found a way to deal with it.

Let me just ask you one other thing. Your approach is similar to the one that we have mapped out legislation called Health America.

There is a period of voluntary coverage where you challenge the private sector to offer coverage by reducing costs and making other systemic changes over a period of time that you have just outlined.

What kind of a response have you gotten from the business community in Florida when you have gone to them essentially with a call for voluntary health insurance coverage and cost containment? How did they react?

Governor CHILES. We had very strong support from the business community, the medical community, even the insurance community, in the direction we went. And in effect, we are having good cooperation.

This is one of the major, major problems for the business community.

Senator RIEGLE. We are hearing that, too.

Governor CHILES. And they see this as one of the ways in which they can make some savings. Certainly, they have asked us, "Give us a period of time in which we can do this and allow the State to help."

So they are at the table. They are participating. They are helping. But they clearly know that we have designed the parameters of the ring.

And come December 1994, if we do not have the 2.5 million covered, we go into the next phase. Having that kind of hammer makes them even more willing to participate.

We are using tools like pooled purchasing and community rating. They will try to help us with holding down the health care costs. They very much want to do that.

They were very supportive of our new law that limits the ability of doctors to refer patients to testing facilities in which they have an interest. They were supportive of that legislation.

Senator RIEGLE. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman. Mr. Chairman, I know you have to be gone for a few moments. I will be glad to take over.

I am just going to ask a few questions and yield to our colleague, Senator Baucus. So if you have to leave. I know you are coming right back. And we will hold down the fort until you get here.

Lawton, you have always been good at getting things done. I have been just sitting here watching you, reminiscing a little bit about your days in the Senate when I had the pleasure of serving with you.

You were always a good consensus builder. Rather than going out and slaying away at all the dragons and what have you, you have always very quietly got people in the room, various groups and people who might have opposing views and opposing thoughts and see if they could come together and reach an agreement. You were remarkable at doing that as a Senator.

And I have talked to our colleague, Senator Graham, former Governor Graham, I should say, sitting with you right now at the witness table.

And I marveled with Senator Graham about how you evidently have been able to build a consensus on some very, very controversial and emotional issues on health in the State of Florida. We talked about that. Your ears would have been burning, as we say.

How did you do that? Where did you start because we are having a hard time doing that here?

We see the business interests say, "Oh, no. We cannot participate." And frankly, I think most businesses want to participate in business.

They want their employees to have a program. They want to be a partner, but many just cannot afford it.

We see the doctors saying, "We do not want any cost controls." We see the pharmaceutical companies who are saying that we do not want any cost control.

How did you get people to agree on some of these principles?

Governor CHILES. I thank you for your flattering remark. I think more than anything it was the fact that we allowed some time and we set a deadline.

Now, we did have legislation proposed in the Legislature that would have Florida adopt a Canadian-type plan.

And I think that probably had a lot to do with the fact that we were able to say, "Look, we will give you an opportunity to show you can do it on your own. We will put in all the mechanisms that we think should help you short of going to something that is mandated."

So we put all health functions in one agency. We tried to use that to affect a better policing and cost control.

We talked about community rating. We have talked about keeping insurance companies from cherry picking.

All of those steps we tried to put in the mix, all of those things that you can do short of mandatory coverage. It has put the burden on the providers, on the insurance companies, and on the businesses to see how many of these things they can implement.

What we want to do is see how many of the 2.5 million people can we get covered on a voluntary basis. And those we cannot, then we will have to take the next step.

I think it was more of everybody agreeing to something in the future. We got them to agree to something in the future.

Senator PRYOR. Thank you Governor Chiles. Now, we have a proposal by one of our colleagues, Senator Daschle of South Dakota. I am sorry he could not be here.

He told us the other day that he wanted to be here, but I do not think he was able to get here, back to Washington today for the hearing.

He has proposed that we sort of look out there in regions of this country, like the Federal Reserve regions, maybe 12 regions, and maybe collectively the States and the entities could sort of divide up into 12 regions.

He also—and this would be to handle—and I am not saying to ration, but at least to sort of allocate health care under our system.

He also proposes that we abolish HEFA. And that always gets a big round of applause with just about any audience you go before.

Have you had a chance to look at Senator Daschle's proposal?

Governor CHILES. No, sir.

Senator PRYOR. Now, I do not understand everything about it, but I believe it is promising. It is a different sort of approach and it is a constructive addition to the debate.

And if some of them are going to be a little controversial, so be it, but we got to at least have people talking about them. And as you said, you got to scare them a little bit from time to time as to what is going to happen.

But I applaud Senator Daschle for coming forward with it.

There is mentality that has existed in Washington for a long time that implies that unless it comes out of Washington, that it is suspect.

And somehow or another, there is too much thinking up here in this beltway that the States do not have either the expertise or the smarts or whatever to put something together.

Now, I have been out there in the States before. I am a firm believer that the States have taken the lead in this—not necessarily because they want to, but because they have to.

Well, Washington does not have a very good name right now.

The States, you all are doing pretty well with the people. We are not doing quite as well. I was in a parade down in Warren, Arkansas Friday.

And I got there too late and I had to make my own sign. They did not have a sign for my car. They said, "Here. Here's some card board and masking tape." So I was there with a magic marker. And first I put Senator David Pryor.

And I said, wait a minute. I turned the card board over and I just put David Pryor. I was afraid someone would know I was a senator. [Laughter.]

I was afraid someone would know I was in public office.

Governor CHILES. For a long time, you kept the people from Arkansas from knowing when you were running for office.

Senator PRYOR. That is right. [Laughter.]

I told the crowd that day—there were several other fellows running for office, Senator Bumpers and his opponent and others.

And I said, "We are in such bad repute," I said, "I am not even on the ballot this year. And I am afraid I am going to beat." [Laughter.]

So what I am saying, Governor Chiles and Senator Graham, is that I think it is very exciting what you are doing out there on the State level.

I am going to yield at this time.

Governor CHILES. Well, again, Senator, I thank you for being a co-sponsor with Senator Graham and Senator Leahy of the proposal.

And being former Governors as both of you are, you know the importance of allowing the States some flexibility—especially when the national solution looks like it is not going to happen this year.

In our Medicaid Buy-In, we are asking to be able to go up to 250 percent of poverty. We are willing to hold ourselves accountable for what we will do with that money and the number of people we will cover with that money. I think that should be done.

I do not think that Federal Government should ever turn loose tax dollars without a way of assessing how they are spent. The old way was to micro-manage with rules and regulations, telling States exactly how to do it.

Well, we are trying in Florida now with our cities and counties and school boards to look at a bottom line.

You tell us what a bottom line measurement is, for example, what are your math science scores going to be, what is your graduation rate to be, and in this instance, what your coverage rate will be?

The Federal Government should tell us that way rather than tell us exactly how all 50 States must do something. That does not work.

Senator PRYOR. Very good.

Senator Baucus.

Senator BAUCUS. Thank you, Senator.

Seeing you both there, I am attempted to ask you who has got the better job? I mean, you are both Governors and Senators.

Governor CHILES. There is no doubt in my mind. I will take mine. [Laughter.]

Senator BAUCUS. I was curious, too, a lot to the degree in which the Florida plan contemplates Federal dollars. That is, Florida has a lot of uninsured just as the State of Montana does. I am sure many people in Florida suffer from some pre-existing condition as do many in Montana.

Governor CHILES. Yes, sir.

Senator BAUCUS. Does your Florida plan here contemplate Federal dollars to help cover uninsured in Florida with pre-existing conditions, etcetera, and if so, how much?

Governor CHILES. If I had my druthers, we would go up to 250 percent of poverty in a Medicaid Buy-In. In other words, if we could separate health from welfare, the Federal Government would put up a $1 billion additional dollars. And the State of Florida would put up roughly $800 million at its Medicaid match rate.

We think that would cover our 2.5 million people that are uninsured. Now, that sounds like a lot of money. But you need to know that the Federal Government last year had to spend $800 billion in new money for Medicaid costs in Florida.

In other words, the Federal Government, because they are picking up 55 percent of this 365 percent increase, the costs is eating your lunch just like it is eating our lunch.

So what we really think is that we are asking for sort of a front end investment that will control costs over a period of time.

Given the plight of the Federal Government, it probably is not reasonable to think that we would get up to 250 percent at one time. But we think that is maybe the cheapest way to cover this uninsured population.

Now, if you want to ask me can we ever cover our 2.5 million without some increase in Federal assistance? No, we cannot. No way we can pick up that cost totally on our own.

But because we are not picking it up now, we are having this tremendous increase in costs.

Senator BAUCUS. How many Federal health care dollars does Florida receive today roughly?

Governor CHILES. About $3 billion today.

Senator BAUCUS. About $3 billion a year?

Governor CHILES. Yes.

Senator BAUCUS. And under your plan, would Florida receive more Federal health care dollars or fewer?

Governor CHILES. They would receive more if we got what we are asking for. We would get about another $1 billion more.

Senator BAUCUS. And what would the control mechanism be? How are you going to control cost?

Governor CHILES. The control mechanism would be that one, this would allow us to go to universal access which keeps us from having expensive emergency health care.

We could also go to front-end and managed care because we would be controlling it. We would be requiring it to be done with managed care.

We will put in effect steps that we could be measured by or held accountable for as the increased Federal money comes in.

In other words, we would commit to certain levels of coverage. We would hold down cost to certain levels. All of those steps could be put in.

Senator BAUCUS. Do you think that Florida health care cost inflation could be kept at the national CPI?

That is, can Florida commit to instituting whatever measures are necessary so that health care costs do not rise at a faster rate than the CPI?

Governor CHILES. We would certainly be willing to try to do that. And we would certainly agree that it would not increase faster than national health care costs.

Senator BAUCUS. I was just wondering if you had any sense to whether the CPI is a good cap?

Governor CHILES. Well, if you looked at it now, Senator——

Senator BAUCUS. Nationally?

Governor CHILES. Well, if you looked at it now, health care costs exceed the CPI so much.

Senator BAUCUS. Right. That is why I am asking the question.

Governor CHILES. Yes. So I do not want to tell you something that is totally impossible to do, but I believe that we should be able to hold health care costs at CPI.

And I believe if you go to a universal coverage and if you can go to mandated managed care rather than fee for service, then I think you could come close to CPI.

Senator BAUCUS. How do you handle multi-State employer-employee problems under ERISA?

Governor CHILES. Well, I think——

Senator BAUCUS. For example, there are certain companies that have employees in Florida and they have employees in other States. And Florida has its own package which is different from, say, the package in other States.

Governor CHILES. But you see I think any multi-state employer already has a bigger benefit package than Florida's minimum benefits package.

I think the legislation could certainly say that any multi-state plan that was actuarially equivalent to a State's benefit package would be OK. In other words, they would remain exempt.

The only thing what we are looking for is a stick. We must get the business sector to come forward and do all the things we would like them to do by December 1994 without having to go to pay or play.

I know, Senator, that you are one of the original co-sponsors of the Mitchell bill. So you certainly believe pay or play is something we need unless there can be some kind of stick.

Why should a company try to do anything now? We have no control over them due to ERISA. There has got to be some way of doing that.

We think there ought to be a compromise that can also take care of labor's biggest problems which is that there be some minimal benefits.

Senator BAUCUS. No. I appreciate those excellent ideas, but as a former Chairman of the Senate Budget Committee, I know you ap-

preciate how difficult it is going to be to get additional Federal dollars for some of these programs.

Governor CHILES. Absolutely. The only way of doing that I think is to convince you all that you are adding additional Federal dollars every year under the present plan and as long as Florida and every State is out of control like we are.

Just look at your increase in Medicaid dollars that you are spending now. That is the faucet. That is part of this deficit that you are dealing with. It is not a question again of whether you or pay later, you are paying now.

So in other words, if you are increasing your Federal dollars to Florida by $800 million like last year, I am just saying that if you gave us a $1 billion we could cover that 2.5 million uninsured. You would slow down that increase immediately.

Senator BAUCUS. Oh, I appreciate that. And that is why I asked the questions about cost control. This is only going to work if we have meaningful, realistic, hard and fast cost controls for this to work.

Governor CHILES. Absolutely. And you should not give Florida that additional money or any other State without us telling you exactly how we will show you what you get for your money. You should hold us strictly accountable.

Senator BAUCUS. Thank you.

Governor CHILES. Thank you.

Senator RIEGLE. This has been a very important discussion because I think it lays out, and gets right to, the crux of the issue.

The only way we can break this ever rising cost spiral is by, in fact, spending a little bit more on the front end in order to try to get some controls in place and some good health patterns in place so we spend less further on down the line. And it is a classic investment strategy.

But you are quite right in saying with costs outlays so high today and the squeeze on with the budget and the straight jacket we are in, are we in a position to even make efficient decisions anymore?

Can we go ahead and, in fact, spend more on the front end in order to save ourselves and spend less further down the road, not only just in terms of direct health cost, but we get a healthier country.

I mean, the beauty of this is you get a double-barreled effect if we do this intelligently. One is you save a lot of money that you otherwise are going waste. And number two, you have healthier people.

You do not wait until they go through these cycles of getting sick and getting so sick that they show up in an emergency ward and get this high cost care and can't function or die or in some way become disabled or out of the work force for several months.

Governor CHILES. Yes.

Senator RIEGLE. So this is what every other Nation one or another has done is they have found the way to do what it takes to be efficient on the front end.

And what we are doing is we are living with an uncontrolled system that is wildly inefficient and it is giving us a lot of bad health at the same time.

So I mean, we can pay either way. We can either pay more dollars as we go on in time and have a poorer health profile or we can spend some additional amount of money on the front end, slow down these excessive costs in the future, get rid of a lot of them and have a healthier Nation. I mean, that is the choice.

And we can decide it either way, if we could just get that issue framed in terms of the choice, the roads, and the paths that we have available to us.

I think whether you have an electronic town hall meeting as Perot was suggesting or something else, most people in the country if they understand that choice would say take the rational choice. Let us go down that rational road together because we are going to be better off as a result of it.

And so I appreciate the discussion back and forth because I think it is right at the heart of the dilemma. And we just keep circling at this fork in the road.

We have just got to figure out to take the intelligent fork in the road. And I think we are ready to do that.

Let me thank you very much for your testimony today. It has been very helpful to us. And again, we appreciate your leadership in the State of Florida.

Governor CHILES. Thank you, Senator. I wish I could carry you to Florida to speak to my Legislature because that is the point we are trying to make down there. We must go for preventive care in health, in education, in the environment, and in public safety. We have got to spend some dollars on the front end to stop these escalating costs.

But at the same time, we have to deal with our failures, the ones we have already let slip through. We cannot stop spending on them, but we certainly can try to cut off the spigot and stop any additional ones.

Senator RIEGLE. Well, thank you. You have been very helpful.

Senator GRAHAM. Mr. Chairman.

Senator RIEGLE. Yes, Senator Graham.

Senator GRAHAM. I think this last discussion points out what will be a key part of the debate and that is the difference between cost shifting and cost containment.

What we have characterized as cost containment in many cases has really been cost shifting. Many of the 2.5 million people in Florida who do not have health insurance receive some health care services.

Senator RIEGLE. Yes.

Senator GRAHAM. They go to the emergency room, one of the most expensive and least efficient places to render primary care. They are added to the insurance bills of the Federal Government and every other employer in the country.

And so when we say we are going to not provide for a Medicaid Buy-In so that there is an intelligent means of covering these people, we are not saying that we will save that $1 billion.

Senator RIEGLE. Right.

Senator GRAHAM. We are just saying it is going to be spent in another way. We are making a conscious judgment to shift the cost to someone else.

I think that needs to be a key part of our understanding of what the economic realities are.

Senator BAUCUS. Senator, if I might respond.

Both cost shifting and cost containment have to be addressed. We have to address cost shifting. You are right. There is this cost shifting as you described. The problem is this country has not addressed cost containment either.

Governor CHILES. Yes, sir.

Senator BAUCUS. And both are equally important. And our system is going to fail if they both are not addressed in a meaningful, realistic way.

Governor CHILES. Right. But, Max, for years, I used to think that we had to have cost containment before we could have universal coverage. I labored under that.

I now am so convinced, you will never get cost containment without universal coverage.

Senator BAUCUS. Oh, I agree with that.

Governor CHILES. Yes.

Senator RIEGLE. That statement alone is such a powerfully important fact that these things have to be tied together because otherwise you have got a system that is designed to be out of control.

And what is going to happen is the woman is not going to get the mammogram. And she is later going to come back with an advanced breast cancer with terrible problems for herself and very expensive care.

Or the man is not going to get the prostrate cancer defined early. And he is going to come back later with a terrible problem and huge bills. Or the expectant mother is not going to get the prenatal care.

And the baby is going to come in under weight and maybe have $200,000 worth of hospital bills in the first 90 days of it life before it can even go home.

I mean, we have a humane choice that fortunately lines up with a good solid economic choice.

Governor CHILES. Right.

Senator RIEGLE. We can actually help our people and spend less money if we make this shift in terms of how we manage this system. And the question will be now whether we can marshal the will to overcome all the divergent voices.

And it should be said as well that there are some people making an awful lot of money with the system the way it is now.

Senator Pryor has pointed this out as much as anybody around here. And that is to have a system out of control does not mean that somebody is not becoming a millionaire or a quasi-billionaire in cashing in on the system the way it is now.

They do not want the system changed because the system is working beautifully from the point of view and the position that they have in the game.

And in the broad public interest, that has got to be stopped. I mean, we have got to rewire this system, re-engineer it as you are trying to do in Florida. And we are going to do everything we can to try to get that done here.

Thank you both very much.

Governor CHILES. Thank you.

Senator GRAHAM. Thank you.

Senator RIEGLE. Let me know call forward our other Governor who is here with us this morning, the Governor of Hawaii, Governor Waihee, who has come to us from a great distance.

And I want to say how much I appreciate the fact that you have been willing to come so many thousands of miles for the purpose of testifying before this hearing today.

You have in Hawaii an employment-based health care system that has now been in place about 20 years. And so since 1974. Am I right in that?

Governor WAIHEE. Since 1974, Senator.

Senator RIEGLE. Yes. So you have had almost 20 years of experience with it. And everything that we have been able to hear about it has generally been positive. I am sure it is not a flawless system or a perfect system.

Governor WAIHEE. No.

Senator RIEGLE. But I understand from what we have been able to learn that the citizens of Hawaii seem to like the system, they seem to be showing good health profile results in the system for a length of time, and that you have been able to achieve certain efficiencies in the operation of your system.

I want to also say that I am especially pleased to welcome you here today. We are proud for Michigan about the fact that you were able to get your college work done in our State of Michigan.

And I know recently, you were out to receive an honorary degree from Central Michigan University in Mount Pleasant where you spent some time.

So I feel very flattered by the fact that we can sort of call you at least in part a son of our State as well. And we appreciate your leadership in Hawaii.

And we will make your full statement a part of the record.

[The prepared statement of Governor John Waihee appears in the appendix.]

Senator RIEGLE. I know you have Dr. John Lewin with you, who serves as the Director of Health in your State. We are very interested to have your insight and your advice as to what you have found in Hawaii and how that might apply to what we should be doing nationally now.

STATEMENT OF HON. JOHN WAIHEE, GOVERNOR OF THE STATE OF HAWAII, HONOLULU, ACCOMPANIED BY JOHN C. LEWIN, M.D., DIRECTOR OF HEALTH FOR THE STATE OF HAWAII

Governor WAIHEE. Thank you, Mr. Chairman and members of the committee. I want to thank you for inviting me to join your former colleague and my current colleague, Governor Chiles, to participate in this very important meeting this morning.

I also want to thank you, Senator, and the good people of Michigan for my education as you indicated.

Those of us here today are all painfully aware of the problems regarding health care. As many as 37 million Americans lack health insurance, and their numbers increase each year.

Nationally, we have health care statistics which, in many cases, match those of third-world Nations.

Health care costs are increasing at a rate that frightens people—and now encompasses about 14 percent of our Nation's gross national product.

We know the problems, yet we seem to be no closer to solutions. Each day we continue to debate the merits of opposing programs, each day we delay action, is a day closer to a health care system that only the wealthy can afford.

It is clearly time for action—aggressive, decisive action. It is clearly time for national reform—the kind of national reform that you, Mr. Chairman, and your colleagues have been trying to construct.

However, until national reform is achieved, I believe it is the States that must be looked to to take the first steps. And States need more tools to solve their own problems—tools such as ERISA waivers and Medicaid-Medicare flexibility.

Therefore, Mr. Chairman, we want to join our support to the concept of flexibility embodied in Senator Leahy's and Senator Pryor's legislation.

These may seem simple solutions, but they work. Let me tell me you how.

Hawaii's residents have 100 percent access and 98 percent coverage in basic health care. And do you know that most of us in Hawaii take this for granted? We are a matter of fact about our near universal health care. In fact, a Harris Poll released today by the Kaiser Family Foundation and the Queen Emma Foundation shows Hawaii's residents more satisfied with their health care services than the rest of the Nation—in fact, more than 10 percent higher.

We have 17 years of employer-mandated coverage and 26 years of Medicaid. These two alone cover 95 percent of Hawaii's people. Recent implementation of a State subsidized insurance program takes in the remaining gap group.

I believe that Hawaii's experience in universal access at affordable cost can be a model for a national health reform package. Indeed, many States are already using portions of the Hawaii system to enact State-level initiatives.

The fundamental goal of the Hawaii system is universal access. What we have demonstrated is that universal access is not only good social policy, it is good economic policy.

Access is a cost-cutting device. When people have affordable access, they seek primary and preventive care. Only 17 percent of Hawaii's residents report postponing health care they felt they needed, compared to 30 percent nationwide.

In fact, Hawaii's health care expenditures are less than Canada and Sweden and, of course, far less than the rest of the Nation.

Hawaii's system is based on an employer mandate, our 1974 Prepaid Health Care Act. The key to our success is that under this system, "everybody plays." Government requires a solid, standard benefit package. However, employers are allowed the flexibility to determine how coverage is provided.

Any employee who works over 20 hours a week, and earns a minimum salary per month is eligible. Employees may be required to pay a portion of their monthly gross wages with the employer providing the balance of at least 50 percent. Dependent coverage is optional.

The Hawaii health care system and its employer mandate exists because of a 1983 ERISA exemption. This exemption, however, literally froze our system to the program that was enacted in 1974. While this exemption has been highly beneficial, we do need additional flexibility in ERISA, in Medicaid, and in Federal health care funding to update the provisions of the Act.

Mandated employer coverage is an effective tool for universal access—without the much feared, negative impact on business; rather, it actually is in accord with America's faith in the free enterprise system, to find cost-effective solutions to complex problems.

Government defines the extent of coverage and uses the competitive marketplace to provide that coverage, cost effectively and efficiently. It also avoids complex, governmental bureaucracies.

Contrary to small business fears, our mandate has not brought about a bad business climate. Hawaii is a small business State. Ninety-seven percent of our businesses employ fewer than 100 persons, and 94 percent, 50 or less. We have a steady rate of overall business growth. Unemployment, which was high at the time that our mandate was enacted, has actually declined to the point that we have the lowest or close to the lowest rates of unemployment in the Nation.

While I cannot suggest that our small business success rate is due to our health care system, there is more than enough evidence to prove that our health care system has supported small business.

For example, a premium supplementation fund for small employers unable to pay for coverage was created with a $1 million trust fund appropriation back in 1974. Since that time until today, 17 years later, the fund has paid out less than $100,000 to supplement any business' insurance—in fact, that fund is getting more in interest than it has in payouts, and the legislature recently considered abolishing it altogether.

The second element of our system is voluntary—the community rating of our two large nonprofit insurers. Through a community rating, our small businesses enjoy health insurance rates that are among the lowest in the Nation, and are not subject to medical underwriting and experiential rating practices.

With all employees in the risk pool—and I think this is a very key point—it is good business to offer competitive rates through community rating.

Insurance reform is also vital to the success and equity of the Hawaii system. Affordable insurance rates are possible due to the prohibition of such practices as exclusions and non-renewability.

Now, we recognize that other States may not have the dominance of nonprofit insurance providers that we have in Hawaii. We believe though that our National framework for just insurance practices can take the place of voluntary compliance that exists in Hawaii.

Medicaid is our third element, serving over 90,000 people with a generous package of benefits, including most of the options allowed under law. We cover those categorically eligible up to 62.5 percent of the Federal poverty level, as well as maximizing Federal coverage options.

And last, our relatively recent State Health Insurance Program, "SHIP," offers a basic benefits plan to over 17,000 of the "gap-

group," the working poor who are ineligible for Medicaid and prepaid health care.

SHIP emphasizes prevention and primary care. Coverage is provided by private insurance companies with subsidies based on a sliding fee scale supplied by the State.

While Hawaii's system has received much attention, there are still those who feel that it is an anomaly. It is illustrative, however, that the State by State reform discussions now going on contain many, if not all, of the elements of our system.

In this context, Mr. Chairman, I would propose the following suggestions for national health care reform based on Hawaii's system, and improvements that we seek, all of which are not possible without action at the Federal level.

Briefly, my 10-point plan for national reform rests on a basic benefits plan for every American, provided to the extent possible through a simple, "everybody plays," employer mandate.

National insurance reforms are included to ensure that small business persons are provided with affordable coverage options. Tax incentives from the Federal Government assist all businesses with the cost of coverage, but only that necessary coverage entailed in the basic benefits plan.

A standardized claims process provides both increased administrative efficiency as well as data vital to an enhanced program of consumer education. Also working with this information, cost containment commissions at both the Federal and State levels need to limit cost throughout the system.

Tort reform and medical practice parameters ensure that the intricacies of legal liability do not undercut or unduly inflate the cost of good medical practice. Closer coordination of the public and private health care sectors provides assistance and a safety net to persons having difficulty with access to the private system.

And finally, Mr. Chairman, a Federal set aside of funds earmarked for prevention activities, so often overlooked, but so vital to the success of our efforts in long-term cost controls.

Hawaii's experience shows that health care reform can be accomplished, while maintaining the basic strengths of America's health care system. But I believe success rests on the following principles:

First, public health and prevention must be a priority with those of us who have the authority to affect reform. It is certainly a priority with the American people, who rank health care as their biggest worry after the economy.

Second, primary care, focusing on a community-based medical home for each citizen, must be the foundation of access efforts. Primary care is effective in lowering the need for more expensive care. It is vital that each of us have a regular source of such health care.

And finally, I leave you with the thought that the government does not need to run the health care system. Its presence in the delivery of care, setting of reimbursements or payments may stifle any creativity which made the American health care system the best in the world. Government does need to set and enforce rules so that a fair and equitable market can operate.

We have a formidable task if we are to give the American people any relief. I pledge to work with you, your colleagues in Congress, my fellow Governors, and anyone concerned as we undertake the

efforts that are necessary to achieve national health care reform for our Nation. If we are to succeed, we must break down the barriers, and we must do so now.

We join you enthusiastically in this effort.

Thank you, Mr. Chairman.

Senator RIEGLE. Well, thank you for an excellent presentation. And again, we are very much in your debt for traveling so many thousands of miles to come and bring that important Hawaii experience to us.

Do I understand from what you said that if we were to compare the cost, say, of health insurance for a family of 4 in Hawaii and the same cost for the same kind of coverage now for a family of 4 somewhere else in the United States that you have data that would show that that cost on average is significantly lower in Hawaii. Is that correct?

Governor WAIHEE. Yes, Mr. Chairman. Also, our data will demonstrate that our cost is a little lower than even the cost in Canada.

Senator RIEGLE. So you have a major cost advantage in terms of the system that you have put in place.

Now, is there data also to show just the health profile of your people in terms of how they are doing as opposed to, say, the health profile of people in the other 49 States under a different kind of health care system?

Senator PRYOR. He wants to know how much pineapple people eat. [Laughter.]

Governor WAIHEE. I think, Mr. Chairman, what our experience shows is that first of all our system has many of the same problems that the health care system has across the Nation.

We face the same kind of cost profiles on an item by item basis that are found elsewhere in the country. Cost containment is definitely one of our big issues.

We also as a State really do not have any significant cultural or geographically-based differences in the profile of our population. Indeed——

Senator RIEGLE. From the rest of the country?

Governor WAIHEE. From the rest of the country

Senator RIEGLE. Yes.

Governor WAIHEE. Indeed, one of our unfortunate statistics is the fact that Native Hawaiians, for example, which make up about 20 percent of our population suffer higher negative health statistics than many, many other sub-groups in the country.

What we do have though—and that is what leads us to believe that access is a cost-cutting tool—are some utilization statistics that are much better than the rest of the country.

Senator RIEGLE. Yes.

Governor WAIHEE. And Jack has those types of things on his fingertips. So I will just pass you over to him and he can give you the information.

Senator RIEGLE. Yes, please. And also apart from some of the myths about the cultural assumptions that people would make about Hawaii, I am also wondering, too whether the style of life, the patterns of living in Hawaii would tilt toward better health,

fewer health problems, longer life, whatever that you have seen in data.

In other words, is there anything else we should try to sort out of the experience that would be in effect unique to Hawaii?

Dr. Lewin.

STATEMENT OF JOHN C. LEWIN, M.D., DIRECTOR OF HEALTH FOR THE STATE OF HAWAII, HONOLULU

Dr. LEWIN. Thank you, Senator.

I would like to submit an additional part for the record, a paper on the Implementation of National Health Care Reform with Lessons from Hawaii. It contains a lot of comparative data that you are looking for.

Senator RIEGLE. Thank you. We are glad to have it.

Dr. LEWIN. But along the lines of lifestyle genetics and the great theory of the moat which are the often-stated myths about Hawaii that would make us, in some people's mind, allegedly non-transportable, let me give you some brief information.

Senator RIEGLE. Yes.

Dr. LEWIN. In terms of lifestyle, we do compare better than the average State in America, but we are nowhere near as well off in terms of lifestyle choices as are the States of Utah, Vermont, New Hampshire, Minnesota, and many other States which are ahead of us.

Our reductions in cost cannot be attributed to lifestyle on that basis. We have a high percentage of people who are sedentary. We have high numbers of people with hypertension.

To give you an example, we have one of the highest in the Nation's rates of breast cancer among our total population. And yet on the outcome side, we have the lowest death rates for breast cancer.

That is not lifestyle. That is a health care system working the way we want it to, detecting the problem early and treating, of course, the disease.

In terms of genetics, we ourselves thought for some time because of the high percentage of people who are Asian-American in our State, 20 percent Japanese-American, another 6 percent Chinese-American people, that perhaps the genetic element was involved.

We see now though, looking—in fact, early generations of people who came from Asia to Hawaii did, in fact, have lifestyles that were more advantageous.

Modern citizens in Hawaii of Asian ancestry have health status indicators in terms of years of productive life lost with clear data indicating that they are in greater risk than Caucasians.

So the genetic factor does not work, particularly when you have the 20 percent Hawaiians with health status rates below the black population of the District of Columbia.

Senator RIEGLE. What about immigrants?

Dr. LEWIN. Immigrants who have come into our State. We have the same kind of problem with the Pacific Islanders who come to Hawaii for health care. So we have those issues. Genetics and lifestyle really do not work.

The business issues are often cited. The businesses cannot go across the State borders. But I think people fail to see the fact that

we do have almost all the same businesses coming in and out of Hawaii as other States have. And the issue that they fail to talk about is our insurance rates are much, much lower for businesses.

Our mandate has not resulted in higher cost, in fact, lower cost.

Governor WAIHEE. Why don't you give the Chairman the hospitalization utilization rates and the like.

Dr. LEWIN. Our hospitalization rates which are included in the paper that we are going to add are one-third lower than the national average. Our emergency rates are one-third lower. And there is the source of our cost reductions.

We are treating people on the out-patient basis better than we are in——

Senator RIEGLE. That is partly the answer I think to Senator Baucus' question, too about whether you spend money on the front end for preventive care and health care planning and prevention and so forth rather than catch people later on after problems have developed and then pay the high cost to try to fix the problem.

And it sounds to me like you have had enough experience now to bear out that argument. In other words, you have got now essentially a 20-year profile history.

Dr. LEWIN. Right.

Senator RIEGLE. To show you that if you go this alternative route, you can get these financial and health benefits. I mean, that they accrue over time with a better health picture for people and at a lower cost.

Governor WAIHEE. Our health outcome is something we are very proud of. I think that there are basically two general reasons why we believe that access is a cost-cutting device.

The first is something that we have discussed quite a bit this morning and that is from the side of the public health professionals and government that universal access brings with it the ability to take care of problems before they become worse. I mean, primary care is emphasized. Prevention is emphasized.

There is a second aspect to universal access as well. And in terms of those that have to provide health insurance, from the insurance industries' point of view, universal access also makes a much larger market from which to sell insurance, too.

And so what you have in many cases—and I believe it has been our experience in Hawaii that when we went into the gap group insurance that there are many people out there who are, in fact, healthy and do not have insurance, or who are postponing the treatment of minor ailments until they become worse who do not have insurance.

What you need to do is to include those people into the insurance market now before they become ill in order to generate the financial basis for taking care of them when they are sick.

And this is the reason why our health insurance companies in Hawaii have been in favor of universal access. It is their business to get as large a market of healthy people as possible prior to ailments.

So there are two ways that universal access works to cut costs. It does it by providing the ability to take preventive action. It also does it by creating a larger market for those that are selling insurance.

Senator RIEGLE. Just one other thing and then I want to yield to Senator Pryor and then to Senator Packwood.

Would doctors, say on average, earn more or less in Hawaii than they earn on the mainland? Do you have comparative data there? And the same thing with respect to, say, hospital rates per day. Are they higher or lower?

We are trying to figure out the degree to which this 20-year system at work has affected those kinds of things.

Governor WAIHEE. We do have that kind of comparative data, Mr. Chairman. For the most part the cost of the doctor salaries, hospital costs, and the like are pretty much the same as they are nationally. I mean, there is no particularly difference in those rates.

And, in fact, those costs are superimposed on a cost of living that is substantially higher than most States in the Nation. I mean, Hawaii as a State has a higher cost of living than most States in the Nation.

Now, if you talk to any individual doctor in Hawaii, there is a tendency for a substantial number of them to feel that they are underpaid and overworked and they probably are when they are saving lives. So I do not think that you have that kind of satisfaction, but I do not think our cost is any different than it is anywhere else in the country.

Dr. LEWIN. Hospital costs are running $1,500 a day and up, doctor salaries and Medicaid are comparable to Western States and with most, in fact, national State averages.

We also have for the record insurance premium cost comparisons between Hawaii and New York, Kansas, Delaware, Georgia, California, Iowa, Massachusetts, and other comparisons taken by Blue Cross with programs that have comparable benefit packages in those States.

And it shows that our rates are at least 50 percent less than those other States for individuals and for families.

[The insurance premium cost comparisons submitted by Governor John Waihee appears in the appendix.]

Dr. LEWIN. But one point which does not show is that in almost all those States, Blue Cross has a deduction system where people have to pay up front for the first amount.

That is out-of-pocket. Our State is first dollar coverage for all the programs in Blue Cross-Blue Shield and Kaiser.

Senator RIEGLE. I want to conclude now by simply saying that I think what the Hawaii experience shows, especially after you explode some of the myths about the cultural assumptions that are made and the fact that your profiles are really quite comparable to the rest of the country, the ones that would count in this area, is that comprehensive health insurance works.

I mean, you are coming in here with a 20-year track record of experience and you are able to show better health, lower utilization at the serious end of the spectrum, better cure rates on things like cancer when you find it, much lower insurance rates, and a high level of satisfaction of your people right across the board from your citizens who get the coverage to your businesses who are the primary providers of coverage.

It seems to me that what Hawaii demonstrates is an intelligently engineered comprehensive health insurance plan where you have got everybody covered and you have got a system of cost controls works and can be made to work and you get a whole lot of benefits.

Now, you may have with the transition nationally some start-up costs to do this as I assume you may have had in Hawaii 20 years ago. But once you design for yourself an intelligent system and you phase it in and you start getting these better health profiles and better cost performance coming out through time, you can get to the place where this whole country needs to get to.

Governor WAIHEE. I think, Mr. Chairman, that for the most part what you are saying is pretty accurate. I do not want to mislead you on one point though, and that is, we are suffering from the same kind of cost containment problems that the rest of the country is going through.

And I am actually looking toward other States to see how we can improve our system in terms of costs of individual items. It is an area that we would like to see improvement and we are working on it.

And I think though that the point I want to reinforce is that the primary reason for the results we have been able to achieve with the low cost of health insurance is as a result of access more than any kind of extraordinary, innovative cost cutting devices.

For example, in the future, we want to move more toward managed care and things like that which we feel would even further improve our system.

If the Hawaii experience speaks for anything I think it speaks for the proposition that access done on a rational basis can, in fact, lower health costs in the long run.

Senator RIEGLE. Thank you very much.

Senator Pryor.

Senator PRYOR. One quick question, Governor. I am fascinated by the Hawaii plan and what you have been able to do.

I thank you as all of us do for sharing the Hawaiian experience with the committee this morning. We have all been intrigued by it. And thank you very much for a fine presentation.

As to the insurance companies that participate in Hawaii, do you have fewer or more companies?

I mean, for example, you would think that the companies might say, "Well, if we cannot charge a higher rate, we are just not going to do business. We are not going to cover anyone in Hawaii."

What has been the experience there?

Governor WAIHEE. Well, we started by having two major competitors, essentially, the Kaiser Health Plan and Blue Cross-Blue Shield, two nonprofit insurance companies.

And one of the reasons for the early passage of the employer mandate in Hawaii, if I can be anecdotal about this, is that it happened to be the home of Henry J. Kaiser.

And old Mr. Kaiser just believed that everybody should have insurance. And he was going to sell it to them. So he went around making that known.

You need to know that as a result, the Blue Cross-Blue Shield people have always been in competition with them. In recent years,

we have seen more and more insurance companies coming down and also selling insurance in Hawaii.

So we have a number of other insurance companies that are selling in Hawaii. They all play by the same rules. We have not had to mandate community ratings. The reason is that the two major insurance companies have done it voluntarily.

In fact, when we passed this law in 1974, small businesses went along with it because they saw the advantage of community ratings and as an opportunity to buy cost-effective insurance. And most of that, as I indicated, was done earlier.

So we have an extremely competitive market with two major entities that is now becoming more competitive over the last 10 years or so as additional insurance carriers have come to Hawaii.

Senator PRYOR. Senator Riegle has just written me a note a few moments ago. And he says, "Well, I have just discovered the solution to America's health care crisis. Let's all move to Hawaii."

Governor WAIHEE. If you want to move to Hawaii, Senator, and pay the fantastic prices we have to pay for houses and find a job there, we want people like that.

Senator RIEGLE. Thank you.

Senator Packwood.

Senator PACKWOOD. Governor, a quick question. When the bill was passed, did you ever consider play or pay? Or did you just decide to go play period and that is the way you wanted to do it?

Governor WAIHEE. I think there was some thought about doing that, but then again it would have been a question of where to draw the line. And so we decided instead that if we are going to make a commitment to universal access, then all employers ought to get involved.

And the solution was the creation of the premium supplemental trust fund so that if any employer could in effect demonstrate that they could not pay their premiums, the State would pick it up.

And as I indicated in my testimony, since we established the fund for $1 million in 1974, we have used something like $85,000 in total over the 17 years.

And so it really was discussed, but it was not really a major option.

Senator PACKWOOD. And I know you have a few people who fall between the cracks, the part-time employees, some people on commissions. And those you pick up with your State health insurance plan.

Governor WAIHEE. Right. We do have that. That is also an insurance-based plan where we work with the private sector to provide that insurance. And the people who are enrolled in it pay a sliding fee scale that is established by the Department of Health for their insurance.

Senator PACKWOOD. Now, my last question and I notice that is the last thing in your closing statement, government does not need to run a health care system.

I take it if we were making an option between a play system or even a pay or play system and a single payer system, you would certainly opt for the employer mandate.

Governor WAIHEE. Yes.

Senator PACKWOOD. Rather than wiping it out and the government will pay for it all and run it all.

Governor WAIHEE. Yes. I think that we can—well, the Hawaii experience at least for us has demonstrated that with regard to the general population health insurance, if government sets clear mandates and rules and includes everyone in the process that would be a better way to go than creating a new entitlement-type program.

But if we keep falling short of it, I personally believe that some kind of national plan is better than what we now have.

I would much rather have some kind of universal insurance coverage than have the system where there are, in fact, no national parameters, no national mandate, or encouragement, which is the current situation.

Senator PACKWOOD. Thank you, Mr. Chairman.

Senator RIEGLE. It just occurs to me. I wonder if we have the capacity to estimate over some relevant period of time what the health care costs would be that end up being paid by somebody, the actual out-of-pocket dollar cost of, say, 35 to 40 million people who have no health insurance.

We could, in fact, track them through time in a model so that we know in effect the cost burden that ends up getting bounced on everybody else who is actually picking up the tab.

I fully accept your proposition that if you start with a situation where everybody gets decent health care from the beginning, you get tremendous benefits, health benefits, dollar saving benefits. There is obviously a number of human benefits.

Governor WAIHEE. Mr. Chairman, I think I would even suggest—and I cannot do this as forcibly because our data is not as strong—but I would even suggest that the initial cost of universally mandated health care may, in fact, be lower in cost to the individual employers.

Senator RIEGLE. And the cost shiftings are kept in.

Governor WAIHEE. Yes. Because of cost shifting, our insurance people will tell you that one of the advantages of universally mandated health insurance is that they have a much larger market.

If you went into community ratings and added a substantial number of people who would be paying into the system at the same time, you may find that while the total, the aggregate amount of resources coming into the system may increase, the actual charge to the individual participant may, in fact, go down. And that is what happened in Hawaii.

In 1974, when we implemented the program, our costs were identical to California's. Today, our costs are 60 percent less.

There is really no other difference for it than the fact that everybody has to pay a share of it and everybody has a chance to get preventive care.

So there are two parts for this. Yes, it is true that when you begin the system and people start having the advantage of primary care, that will show up in subsequent years.

But the second part of access is that you create a market and you level it off. I think this is the part that we have not discussed enough in this debate. And that in and of itself may make an immediate difference in health care cost.

That is the reason why the business community, or segments of it, went along with this in 1974. When we passed this Act in 1974, Hawaii was in one its worse recessionary periods.

It was the year before we had the highest unemployment rate in our history since Statehood. We were in the situation where the oil embargo was on. And for an island State not being able to receive any oil, we had literally shut down our economy.

And one of the reasons why people went along with this idea was that they felt that they were going to lose their health insurance. And it was in that kind of climate that we passed this.

The small business community, which by their nature do not want government to mandate anything, went along with it because they saw it as a way to actually reduce health care cost through community ratings and to increase the economic base.

And that is a side of this story that I do not think has gotten as much attention as it should have. And in Hawaii and in other places where we hold conferences, we have had our health insurers testify to that economic fact of access.

Dr. LEWIN. Governor, may I just add to that. When we started, the Governor had the courage to go ahead with the SHIP program which was an additional taxpayers' cost to get to that group.

And the fears were that this group had been uninsured, they were sick, the cost would be tremendous, and the State would be saddled with a horrendous increase in hospital cost, and the budget would just mushroom.

But the Governor had the courage to go ahead with it. The legislature went ahead. What happened with SHIP in the last 2 years is that we have seen that the primary and preventive care services have really worked.

The cost of the program has not increased. It is the only part of our insurance system that has not. And, in fact, there may be a myth in America that front loading the system is going to cost more money than we think.

It may very well be that we will see immediate reductions in emergency room and hospital costs as we have in SHIP.

Governor WAIHEE. Senator, I do not want to belabor the point, except that this is the first time that we have been able to make this particular point this strongly in this forum. But I think a lot of times we see the concept of universal access through the eyeglasses of the Medicaid program.

And when we look at Medicaid and we know that expanded it is inevitably going to cost money and the like, it seems to color our thinking that access can only come by having cost control first.

I think though what we have shown and what we are talking about may be actually pointing out one of the essential flaws in the Medicaid program and that is that people use Medicaid when they need it.

So your population in Medicaid is a group of active users. Instead, they ought to be enrolling in Medicaid to get preventive care, or when they could contribute.

So that the people that go into that program are, in fact, in need of medical attention and cannot contribute.

If you can look at the consequence of a population that is essentially healthy, but uncovered, who can contribute to their own med-

ical costs, that is most of our uninsured population, and who could take advantage of it when they should, meaning that they can receive primary and preventive care a lot earlier, you have an entirely different world than the government entitlement program.

Senator RIEGLE. Yes.

Governor WAIHEE. You have something that may, in fact, not be as expensive initially as it is made out to be. And I think that the Hawaii experience also demonstrates this because we did not, in fact, see this huge up front cost that allegedly was supposed to occur.

Senator RIEGLE. Yes. Well, it provides a powerful, additional argument because it says that instead of having this big cost spike on the way in that you may, in fact, be able to move to the system and realize an immediate set of gains.

In other words, because you are getting some level of contribution from those who can make a contribution, but you are getting another contribution in terms of a better health profile.

Governor WAIHEE. That is right.

Senator RIEGLE. I mean, people start to get on a better a health profile track so they become less expensive users of health care as they go down the time track. So you get both advantages.

Governor WAIHEE. I know that when an employer currently is not buying health insurance, the additional cost of health insurance for the employees is going to be an added expense. I mean, that is something we cannot get around.

But to employers who are already paying for health insurance, the opposite may be true because they no longer will have to pay for all of society's burdens through cost shifting, through uncompensated care. They may immediately begin to feel some relief in their insurance payments.

Senator RIEGLE. Another way to say it is the way we do it now is we create a large number of walking wounded in the country.

I mean, we wait and cause, in effect, a lot of people to get very sick and need a lot of high cost care. And then when they come and get it and cannot pay for it, the costs have to be packaged up and then shifted through this system.

And, of course, as we shift it around, we not only dump it on somebody that presumably should not have to bear that burden, but also you add to the cost.

I mean, just the sheer task of moving it around is expensive because you have to have people to move it around.

And so I think you are quite right. And we will not belabor it now because I think we have a very powerful record here that can help us move forward.

Let me say that we got 4 other witnesses coming. Did you want to help introduce your witness from Minnesota?

Senator WELLSTONE. No. I will defer on questions.

Senator RIEGLE. Well, let me recommend it to all of you because I think it has been some of the most important testimony that we have had.

Senator WELLSTONE. We will definitely look at it.

Senator RIEGLE. Thank you again. It has been very helpful to us.

Governor WAIHEE. Thank you.

Senator RIEGLE. Let me indicate that our next panel includes a representative from the National Governors' Association and experts from the States of Washington, Minnesota, Oregon, and Massachusetts who are going to testify about activities in their States.

Let me now call on Senator Packwood to introduce the witness that is here from the State of Oregon.

Senator PACKWOOD. Mr. Chairman, thank you.

I am pleased to introduce one of Oregon's pioneers in health care, Lynn Read.

Lynn Read has been with the State since 1979 and has directed Oregon's successful Medicaid, managed care demonstration program and will direct the Medicaid portion of the Oregon Health Plan. I am pleased that Lynn Read was able to come to tell this subcommittee about our plan.

And I would like to restate my full support for that plan. Oregon has come up with a solution to the challenge of providing affordable health care.

My State's three part plan would guarantee access to basic health care for almost all Oregonians, no matter how poor or disadvantaged. That is the plan you will be hearing about today.

A lot of attention has been focused on what services will not be covered on the prioritized list. Some critics of my State health plan even like to call it rationing, but we all know that we are already rationing today.

There are 450,000 Oregonians going without any health care today. They are victims of an invisible sort of rationing.

Perhaps the greatest strength of Oregon's plan is the process by which it was developed, a process which I believe can serve as a model for other States.

This process involves public debate and consensus building over health care needs and values. The process also holds the State Legislature publicly accountable for the health care of low-income Oregonians.

This level of public accountability is something I am very proud of. I think the Oregon plan deserves a chance. And all the Federal Government has to do is to give Oregon permission to try this bold experiment, nothing more.

I cannot tell you how proud I am of my State and the people like Lynn Read and John Kitzhaber, the State Senate President, who was the father of this program, who have spent the last 5 years dedicating themselves to coming up with an innovative and daring idea for solving our health care crisis in Oregon.

I am going to continue to fight for the Oregon Health Plan. I believe it is a more rational way of providing health care. And I believe it is what the people of Oregon want.

And I am convinced that Lynn Read will be able to convince you today of the merits of what we are asking.

I thank the Chair.

Senator RIEGLE. Thank you, Senator Packwood.

Senator Wellstone, I know you want to introduce the witness from Minnesota. And we will be pleased to have you do that now.

Senator WELLSTONE. Thank you, Mr. Chairman. I will be brief.

And I will give Curtis Johnson—I probably will not do him justice with this introduction. I asked him whether it could be informal. And he said, "Fine".

Curtis Johnson is the senior advisor to Governor Arne Carlson. And before working for the Governor—and I think this is pretty important—he was the executive director of the Citizens League. In other words, he has a very strong background in public policy.

I think he takes public policy very seriously. I think that is his greatest strength. And in many, many ways, I think Minnesota is one of those States that is a laboratory for reform like the other States that are represented here today.

Curtis Johnson was involved in some very important bipartisan negotiation, Republican and Democratic, which led to the passage of the HealthRight Law.

So I think it is very, very important that he is here today. And let me just finish my introduction, Mr. Chairman, by saying that I am going to stay and listen to people for as long as I can because I am very interested in what different people have to say.

I do think that it is a grass roots, political culture that we live in. And I think a lot of States are getting sick and tired of waiting on us.

They have decided that if the Federal Government is not going to be part of the solution, then they are going move forward. They just do not want us to be part of the problem.

By the same token, I have to say this to you. I have this nagging doubt and fear that if the Federal Government says, "You do it, States," and just stays removed from it all, that within that fiscal structure at the State level, only so much can be done.

And I do not want this to be sort of an excuse for our not moving forward. So I am very interested in what Mr. Johnson and the other witnesses have to say.

I thank you very much for coming from Minnesota. And I repeat what Senator Packwood said. Of course, I am very, very proud of what my State has done.

Senator RIEGLE. Thank you very much, Senator Wellstone.

Let me introduce our other three panelists in addition to the two just introduced.

We have Ms. Alicia Pelrine who is the director of the Human Resources Group for the National Governors' Association. And she is going to lead off the panel today with the views of the association.

We also have Dr. Robert Crittenden who is the special assistant for health to Governor Booth Gardener of the State of Washington.

And then finally, we have Mr. Robert Restuccia who is the executive director of Health Care For All which is a consumer advocacy group from Boston, MA.

So let me welcome you all. We will make all of your statements a part of the record, but we are going to have you make your comments now.

[The prepared statements of Ms. Alicia Pelrine, Dr. Robert A. Crittenden, and Mr. Robert Restuccia appear in the appendix.]

Senator RIEGLE. Ms. Pelrine.

STATEMENT OF ALICIA PELRINE, DIRECTOR, HUMAN RESOURCES GROUP, NATIONAL GOVERNORS' ASSOCIATION, WASHINGTON, DC

Ms. PELRINE. Thank you, Mr. Chairman. I will be brief.

I think we have already had eloquent testimony from two of my bosses. And they more than adequately addressed I think a common perspective for the Nation's Governors and that is that the crisis that confronts us in health care demands a national solution.

But in the absence of consensus about how best to proceed at the national level, what the Governors of the States are asking this Congress to do is work with us in a partnership to provide us with the flexibility and some of the resources that we need to undertake comprehensive initiatives in health care reform at the State level.

There are many who are concerned that if the States move forward with these kinds of initiatives, it will somehow lessen the sense of urgency for national reform.

I think, in fact, quite the opposite is true that States like Hawaii and Florida, Washington, Vermont, Oregon, and other States who are moving forward with comprehensive reform initiatives can prove that there is the possibility of drawing political consensus and taking the political risks necessary to develop a comprehensive initiative at the State level.

I think they also can set up some sense of urgency as people in other States look to those leadership States and begin to wonder why it is that they do not have access to the same kind of health care that their neighbors in neighboring States have.

And lastly and perhaps also critically important is that States can tell us something about the efficacy of the various strategies for both access and cost containment that we all have become familiar with on a conceptual basis.

But we cannot do this alone. And there are essentially three things that I think we could see ourselves as needing from our Federal partners.

The first thing we need is a process that provides three critical ingredients. We need a process that gives the States a one-stop shop, one place where they can go and have the waivers necessary to implement their State-based initiative approved so that they do not have to go hat in hand to 4 or 5 different Federal agencies and wait with the inevitable delay as Oregon has clearly experienced while those Federal agencies make up their mind on each individual State waiver.

Secondly, they need a timely process. Again, using Oregon as a painful example, is it 2 years Lynn?

Ms. READ. Two years.

Ms. PELRINE. Two years later still waiting to implement something that the State and the people in the State have put together and believe is the way to go for them.

And the last thing that we need from this process is some sort of consultative role so that before States actually implement these pieces of legislation at the State level, they have got some sense from the approving authority that what they are planning to do is going to be acceptable and is going to pass muster so that they can get the waiver authority that they need.

So those are the three things we need from a process. Substantively, we need different kinds of waiver authority than we have right now. We need streamlining and expansion in the authority that currently exists in the Medicare program.

We badly need that same kind of streamlining and expansion of the authority that currently exists in the Medicaid program.

Let me give you one example. Not only are the waivers enormously time consuming and arduous to prepare and to defend, but they may have to be renewed every year.

So that you go through the same process every year, never knowing whether the program you have put in place is going to be continued because that is a decision that has to be made at this annual renewal time.

That kind of uncertainty is totally unacceptable to States who are out on a limb in taking the kinds of risks and making the kinds of tough decisions that we are talking about.

They also need waiver authority that right now does not exist. And the one that is probably most critical—and we have talked some about it this morning—is some sort of waiver authority from ERISA preemptions.

We know that is frightening. We know that there are a number of road blocks that the business community and others might put in the way, but let me tell you what States cannot do with ERISA waivers.

States cannot do any kind of assessment on all of the payers in their system to create a Statewide pooling arrangement, whether that pooling arrangement is to provide for some kind of reinsurance mechanism or whether it is to provide for a cross-subsidization of indigent care as the case is in New Jersey whose system was just struck down as a violation of ERISA.

They cannot require employers to offer a package of standard benefits or pay into a public program.

They cannot arguably even develop the kind of common administrative procedures like common claims form and billing procedures that everybody agrees is a great cost containment idea.

And lastly, they cannot establish any kind of uniformed provider reimbursement rates without again running afoul of ERISA.

We are certainly willing, as the Governors indicated this morning to work at a limited exemption to ERISA for States that have put together and passed through their legislatures a comprehensive plan that includes both the access side of the equation and the cost containment side of the equation.

I would love to stop without mentioning financing, Mr. Chairman, if you would like me to. But let me just say quickly that the Governors understand quite clearly the investment strategy to do these kinds of State reforms is going to cost money. States are willing to put up their share of the money.

We sure would like the Federal Government to put some money as well. We are interested in working with you to develop some kind of stop-loss mechanisms so that you have an absolute dollar figure on your liability for any given State program.

But we do think that these projects, these State initiatives cannot be expected to be cost neutral on an annual basis, possibly cannot even be expected to be cost neutral over 5 or 6 years, although

what we can hope for is the kind of rational, cost efficient and effective system that Governor Waihee laid out for Hawaii this morning.

Thank you. I will be happy to answer any questions.

Senator RIEGLE. Thank you very much.

Mr. Johnson, let us hear from you next.

STATEMENT OF CURTIS W. JOHNSON, SENIOR ADVISOR, HEALTH POLICY, OFFICE OF THE GOVERNOR, MINNEAPOLIS, MN

Mr. JOHNSON. Thank you, Mr. Chairman and members.

Senator RIEGLE. And if you could summarize as much as you can. Thank you.

Mr. JOHNSON. All right. Two months ago this week our legislature passed a law that we call HealthRight. This law sets the stage for our State's progress in just about every area of the national debate on health care.

We think it is the product of an extraordinary effort to overcome ideology, partisanship, powerful interests, and general gridlock to get a bill passed.

Like Washington, we have divided government, a Republican Governor and legislature dominated by Democrats. But we had legislative leaders whose vision of coalition politics rose above the usual rules of the competition.

And we have a Governor who simply would not settle for another, predictable standoff between a legislature's will and his veto.

Governor Arne Carlson snowed the political courage and leadership to keep us going on this process until we produced a bill that we could all support.

The story about how the bill not only survived the journey through the legislature, but actually became a better bill is longer than this panel permits, but it is a story of leadership that bridged parties and the branches of government.

HealthRight extends coverage to the only citizens who are now systematically excluded. It commits the State to an aggressive effort to reduce the growth rate in health care spending, while concentrating more attention on the quality of service outcomes.

It responds to rural concerns about hospital closures and shortages of practitioners. And it forces changes in the fairness of coverage for small employment groups.

Let me just summarize very briefly about each of those emphases. On the access question, we do not claim to have revolutionized the system. We get to a form of universal coverage by concentrating on the only part of the population that the current system leaves out.

These are the people we often call the working poor. They are not poor enough to get Medicaid, or old enough to get Medicare, or lucky enough to have employer-based coverage. They are usually working, but they do not make enough to buy coverage without help.

Our law gives them that help, through a sliding-scale of premiums which reflect their ability to pay.

The program heavily oriented at children and families emphasis on wellness and prevention, has out-patient benefits, and it in-

cludes hospital coverage. It is not a welfare program. It is not a hand out.

Second, cost containment. The center piece of our law is the commitment to cost containment. We are establishing a Minnesota Health Care Commission of providers, employers, consumers, insurers, and unions, asking it to devise a strategy that reduces the growth in health care spending while increasing the quality of care. And we realize that is a daunting combination.

The 1993 Legislature expects a report specifying how we can reduce the rate of growth in health care spending by 10 percent per year for the next 5 years.

I should add parenthetically that Minnesota already has average costs 18 percent below national averages. And we are always aware that medical enterprises are Minnesota's largest business sector.

We have over 500 medical technology companies, dozens of management headquarters, more population covered by HMO or managed care arrangements than all but two other States, and, of course, the world-renown operations of the University of Minnesota and the Mayo Clinic.

Our law requires through the Commission that we reach a conclusion for Minnesota on what kind of system we believe will work.

We will have advocates who prefer to move toward that single-payer, government-centered approach with its appealing simplicities and promises of fairness.

Others, especially our Governor, feel strongly that the system should rely as much as possible on private organizations in partnership with an increasingly assertive public role.

We will have to decide where incentives can make a more functional market and where regulation is a necessary tool.

We believe we have the commitment of our health care community to work on this challenge, and that by getting them around the same table with some relaxation of the usual anti-trust barriers, we will find creative, efficient arrangements to raise quality and control cost.

Mr. Chairman, we know that we have the attention of our providers since the access program is financed by a 2 percent tax on their gross revenues.

Third, on small group reform, we simply want to increase the likelihood that people working for small organizations would get coverage through their employment.

So the law requires carriers to offer two alternative plans which specify a more basic set of benefits than the State's usual mandates.

We require guaranteed issuance and renewability of these plans, specify that participating employers must pay at least half the premium.

Gender and family medical history are eliminated as underwriting criteria. The rating bands for health status, age, and geography are compressed significantly.

Fourth, our law reaches out to the concerns of our rural citizens. It evaluates the fiscal status of rural hospitals. And where appropriate, it provides grants. It creates a community health centers program for remote areas.

It addresses the shortage of primary care physicians and other medical practitioners with incentive programs and training.

Most important, it sets up boards by regions to facilitate regional conversations aimed at finding affordable arrangements for quality health care services in sparsely populated parts of our State.

Fifth, HealthRight also commits us to collect data, data about the quality and the comparative cost of medical services to be used for research, for the development of practice parameters, and eventually for consumers and for purchasers to us in designing incentives in benefit plans.

Most of Minnesota's law can be implemented within our own structures and resources, but there are intergovernmental implications.

We will ask for the Federal health insurance credit component of the Earned Income Tax Credit to be assigned to the State; and for whatever flexibility required to coordinate the provisions of our access programs with Medicaid spend-down rules; and for legislation or other action clarifying the standing of our tax as a broad-based health care related tax.

We will want whatever approvals are needed to move Medicaid more toward managed care. And as it has already been mentioned, Mr. Chairman, the recent New Jersey Court decision with all the attention that is getting, we will argue that the Federal Government grant an exemption from the Federal preemption of State laws relating to health care coverage under ERISA.

There is more, but let me say in conclusion that our request to Congress and the Administration is essentially give us the flexibility to demonstrate what our State can do with this approach to health care system reform.

We join the other States that are moving forward with bold new policies and saying: If you cannot lead on this issue, then remove the barriers that hold us back.

The States will demonstrate what works and what does not and create a climate in which a new national policy can be adopted.

I will leave you, Mr. Chairman, with a technical summary of our bill for a complete record.

Senator RIEGLE. Very good. Thank you, Mr. Johnson.

[The prepared statement of Mr. Curtis W. Johnson and the technical summary appear in the appendix.]

Senator RIEGLE. Dr. Crittenden, let me just say to you that Senator Mitchell for whom you once worked as a Policy Fellow wanted to be here today. It is not possible for him to be here, but he wanted to acknowledge his desire to be here.

So we would be pleased to hear from you now.

STATEMENT OF ROBERT A. CRITTENDEN, M.D., SPECIAL ASSISTANT FOR HEALTH, OFFICE OF THE GOVERNOR, OLYMPIA, WA

Dr. CRITTENDEN. Thank you. I appreciate your comments.

Mr. Chairman and members, it is a pleasure to be here today. I will limit my remarks. You have my written comments.

There are three types of States out there now. One type you are going to hear a lot from today are the ones who have actually passed legislation.

Other States are in the early processes of developing that legislation. And in between are the bruised States who have proposed some things and have, in fact, not been entirely successful yet. The State of Washington fits that latter category.

I think we have a lot to share. And I would like to at least start the statement by saying that while we have had a few bruises applied, we are definitely coming to much more consensus in the State. This is an issue that is moving ahead rapidly.

In fact, it is an issue that after the legislature left and went home this past session, the Republican legislators did polls and found that about 80 percent of the people thought that something should be done.

The Republican caucus did a poll of small business. And 60 percent thought the State should regulate the health industry.

A citizen's initiative has been introduced. The Governor is contemplating a special session. This is an issue that is certainly not done. We have a commission actively refining proposals.

I presume that we will see success. I am not sure in exactly what form, but we will see success in the near future.

There are a number of themes that I think everybody has talked about earlier today. And I just want to touch on them briefly.

As Senator Wellstone mentioned, we do want to have some Federal policy. We do not want to do this all by ourselves.

It is very important that we have the cooperation and, in fact, the long-run framework to make this a national system and not just a State-by-State system.

The second issue has been well pointed out there is activity in 35 States at the present time. I mean, it is amazing how many States have come up and are really discussing this in a serious way.

Republican Governors, Democratic Governors, it is not a partisan issue even though it gets discussed that way typically when you start going head to head, but clearly the issue is beyond that and is broader than that.

Senator RIEGLE. May I stop you. Isn't part of the reason for that is that States quite apart from the humanitarian desire to meet really an urgent public need, States, most of them having to balance their budgets at the end of the year, are finding that they are being crushed under health care costs and they have got to do something about it.

Plus, they have a pool of uninsured people out there. So they got that side of the problem as well.

Here at the Federal level, we have the same problem, but what happens is because the health care financing is in a sense an entitlement, we in a sense balloon the budget deficit in order to pay for it, we do not have the iron constraint coming in on us from a cost-control point of view that the States do.

The States are literally being compelled regardless of party, regardless of ideology to deal with the problem because they are being swamped by the cost of a system that is out of control.

We are also being swamped at the Federal level, but there is this dance going on that you sort of dance around the problem because we are able in effect to tack it onto the deficit.

I mean, that is really what is going on here. I think in the end, every State is going to have to respond because it has no choice. It is being forced to do it. And we can look at the pros and cons.

And I appreciate the creativity of States that are getting out front and doing things, but we should be following exactly the same imperative here.

I mean, many of us are trying, but that is the dichotomy that we are seeing. States literally cannot be machine gunned down by the cost being out of control and have to do something about it.

Dr. CRITTENDEN. I would like to comment on that. That is a serious issue.

One of the major reasons that Governor Gardner got involved in health care reform in a bigger way was that he was pushing education.

We went back and looked at our budget in education. And for every dollar that we put into health care, we carved that dollar out of our overall budget, out of education which is 60 percent of our State budget. That is not a very healthy situation for a State or for the future of our country.

I will be very quick to get to the end here. One of the points that Governor Chiles made that I think is important to reiterate and that is that even in the long run when we are talking about future health care reform, States will need to have a role.

There are State differences. New Jersey is different from Montana. Washington is different from Hawaii. We need to organize systems that make more sense locally.

And also as far as managing health care costs, health care is a local issue. You have to get nose to nose and look at how you are going to manage resources. You cannot do that from a distance. That means that you have to have State involvement.

Just briefly, what we proposed in the State of Washington, was a plan that was based on the concept of promoting multiple, private, integrated health care systems with some public oversight.

We proposed equity, accountability, and basically a competitive system, but we also required it to live within a fiscal limits.

We proposed four components. We have a commission. We have health insurance reform. We expanded our basic health plan which is the same as what SHIP is in Hawaii.

We phased in a requirement for employers to provide insurance or coverage for their employees. We figured at the end of that we would have 96 to 97 percent of the people covered which is a great improvement. And we would be able to control cost.

Interestingly, you asked about how long it takes to recover that cost. We ran some numbers. If we reduce our health care inflation in our State overall by about 2.5 to 3 percent, it only takes us 5 years to be able to buy in all the uninsured people. Health care cost inflation is tremendous.

A couple of barriers to mention that we ran into are important. One is the business community does not trust the public sector to control cost. They think we are going to roll over to the providers.

It is very important to create a structure that has the resolve to really control cost. The private sector and business people realize that they cannot do it all themselves. They do need public sector action.

One of the big problems we have, too is that the second best choice for most of the interest groups is the status quo. Health care is the largest employer in the Northwest States, bigger than any other big industries up there.

It is the second largest industry in the country behind agriculture. This is a powerful industry. Their second best choice for each of those different groups is the status quo. And that is where we find these interests agreeing.

Until they understand there is an inevitability of change, they will continue to hold the status quo. It takes leadership and it takes a lot of resolve and it takes the people really saying that something has to be done.

Senator RIEGLE. I am going to have to stop you there for the reason that I need to call on Ms. Read who is going to have to leave shortly because she has another engagement she has got to do. I hate to do that.

But I think in deference to Ms. Read, I have to make that move. And let me call on you now.

STATEMENT OF LYNN READ, DIRECTOR, PRIORITIZED HEALTH CARE SYSTEM, OREGON DEPARTMENT OF HUMAN RESOURCES, SALEM, OR

Ms. READ. Thank you, Mr. Chairman.

The Oregon Health Plan addresses the needs of 18 percent of our population who are without health coverage today. Many refer to our proposal as a rationing plan.

We consider it to be a rational plan for addressing the health care crisis. The Oregon Health Plan is one State's response to the challenge of developing an equitable health care resource allocation policy in an era of limits.

The plan is not, in and of itself, a final solution, but rather a political strategy which creates a process to reach consensus on the policy objective and principles of reform and a framework in which such reform can take place.

Oregon's success in addressing the health care realities of today is due to two factors. First, we separated the health care debate into four fundamental questions and used this matrix to frame our decisionmaking process: Who is covered? What is covered? How is it financed? How is it delivered?

Second, we developed a common policy objective and reached consensus on a set of principles which have guided our reform efforts. Our policy objective is to keep all citizens healthy, not just to guarantee all citizens access to health care.

To ensure the political stakeholders representing vested and often conflicting special interests remain focused on the broad policy objective, we did not start with a completed plan, but rather with a consensus on the following principles: universal access to a basic level of care; a public process to determine what constitutes a basic level of care, based on criteria that are publicly debated that reflect a consensus of social values and consider the good of society as a whole; eligibility for a public subsidy must be based on financial need; and there must be a mechanism to establish clear accountability, both for resource allocation decisions and for the consequences of those decisions.

The Oregon Health Plan was not sold to the interest groups, but instead emerged from them.

There are three basic components to the Plan. First, there is a high risk pool for persons who are denied coverage due to preexisting conditions.

Second, there is a mandate that requires employers to provide coverage, or pay a payroll tax, for employees and their dependents. This mandate on employers is tied by statute to implementation of the expanded Medicaid program. And to help make insurance more accessible and affordable, small group insurance market reforms were passed.

Third is Medicaid reform and expansion slated to begin in December if Federal waivers are forthcoming this month. The elements of the Medicaid plan are quite simple: cover everyone under the poverty level, guarantee them a benefit package which will focus on those services having the greatest impact on their health, deliver those benefits through managed care, and pay for those services at reasonable rates.

The various components of the Oregon Health Plan embrace cost containment with a benefit package based on priorities; reliance on managed care delivery systems; formation of a health resources commission to control use and distribution of costly medical facilities, technologies, and services; and development of practice guidelines by the Oregon Medical Association.

In Oregon, we have designed a process for determining our benefit package based on the clinical effectiveness of various procedures in treating various conditions, and on community values expressed in dozens of meetings held throughout the State. An independent actuary priced the resulting list of prioritized health services.

Within the context of competing needs and available resources, the 1991 Legislature determined what constitutes the standard benefit package. With the priority list, the tools of implicit social rationing have been statutorily eliminated. The legislature is now clearly and inescapably accountable, not only for what is funded in the health care budget, but also for what is not.

Oregonians do not consider our plan to be a substitute for a definitive national solution. We will learn what works and what does not work for Oregon. There will be lessons here for other States and implications for the Federal Government.

Prioritization can be used in combination with other models which must define a basic benefit package, such as a single-payer system or other play or pay proposals.

Areas where further Congressional action is indicated will be identified, such as streamlining the Title 19 waiver process and addressing limitations on States imposed by ERISA.

Until a national solution is enacted, the Oregon Health Plan represents a significant improvement over the status quo. It addresses the immediate health needs of Oregonians and honestly and openly tackles the issue of what medical care is necessary to maintain and promote good health. Thank you.

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

Senator RIEGLE. Thank you very much.

Mr. Restuccia, we are pleased to have you. And we would like to have your statement now.

STATEMENT OF ROBERT RESTUCCIA, EXECUTIVE DIRECTOR, HEALTH CARE FOR ALL, BOSTON, MA

Mr. RESTUCCIA. Good afternoon, Mr. Chairman.

I am going to give you the perspective of another bruised State. With the passage of chapter 23, the Universal Health Care Law, in Massachusetts, it became the first State in the Nation to make basic health care a right of all citizens.

The Law provides some important improvements and access to health care, but it is not a panacea. It does not resolve all the problems of the health care system.

Some of my colleagues call it a Rue Goldberg contraption held together by the glue of State money. At the same time, reports of the Universal Health Care Law's failure have been greatly exaggerated.

Contrary to most accounts, the Universal Health Care Law has not been repealed. Important programs are in place that bring health care coverage to thousands of Massachusetts residents.

The major access program, the play or pay provision has been delayed until 1995, not repealed.

The Massachusetts experience with the Universal Health Care Law offers many important lessons for those concerned with health care reform.

First, State reforms can really make a difference. Thirty-two thousand people are covered by the Health Security Plan, a plan covering unemployed people in Massachusetts.

Twenty-eight hundred are covered by the CommonHealth Program for disabled adults and parents of disabled children. Thirty thousand students are covered by the Student Mandate.

We also know what does not work. State credits do not work. And subsidized insurance for small business does not work.

The second lesson is that the play or pay approach has not failed in Massachusetts. It has not been tried.

Since implementation of this provision has been delayed until 1995, from a policy perspective one cannot make judgments about this approach from the Massachusetts experience.

The third lesson, improving access to care must be combined with containing health care costs. The major problem with the Universal Health Care Law is that the Law fueled health care inflation, increasing reimbursement to hospitals.

On one hand, we improved access to the health care. On the other hand, we gave tremendous reimbursements to hospitals.

Fourth, the States need help from the Federal Government. And this is just to reiterate what everyone else has said. We still do not know whether the play or pay provision is a violation of ERISA.

And fifth, and perhaps most important, is that an active consumer health movement is a key element in winning health care reform. Health Care For All put access to health care on the political agenda in Massachusetts.

Given the provider interests and the special interests in the health care system, an active, involved, informed consumer health movement is crucial.

Health Care For All will continue full implementation of the Universal Health Care Law and a more comprehensive State solution, while working for a national solution to the health care problem we face.

Senator RIEGLE. Thank you very much.

Like so often around here, there are 10 things going on at once that need to all be dealt with simultaneously.

Let me thank each of you. I am going to ask you if you will to respond for the record to following question and we may have others from other colleagues who wanted to be here this morning.

Most of the State programs discussed in this panel with the exception of Minnesota used the current employer-based system to expand private health insurance coverage.

And I think as you all know, that is the approach that we use in our HealthAmerica Plan drafted by some of us here in the Senate.

And I would like each of you to comment on this particular model and the benefits that you see from your State perspectives to this approach. And also, how important is it to have a strong cost containment program at the same time?

And if a strong cost containment program were to be put in place, does this not have the effect of helping employers and make the requirement on employers less financially burdensome than it otherwise would be.

I think we had a lot of testimony earlier this morning that would suggest that, but I would appreciate having a response from each of you to that question.

And I want to thank you again for coming and thank you for your patience. This was a long hearing because we had questions to address to other witnesses and we got a little late start.

So let me thank you all again. It has been very helpful for us.

The committee stands in recess.

[Whereupon, the hearing was concluded at 1:30 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR DANIEL K. AKAKA

Mr. Chairman, I commend you and the Finance Subcommittee on Health for Families and the Uninsured for holding this hearing on state health care reform initiatives. The time has come for Congress to extend health care coverage to the over 34 million Americans without health insurance. Some states have been forging ahead in this effort, and I am proud to say that Hawaii is one such health pioneer.

Today, the Subcommittee will receive testimony from Governor John Waihee, Hawaii's fourth elected governor and first elected governor of Hawaiian ancestry. Governor Waihee is currently the Chairman of the Democratic Governors Association and serves on the Executive Committee of the National Governor's Association.

Mr. Chairman, we will hear from Governor Waihee about Hawaii's longstanding commitment to make health care available to all its citizens, and how we have reached near universal coverage. Because of its commitment to health care, Hawaii ranks among the healthiest states based on indicators such as low infant mortality, low hospital utilization, and low chronic disease rates.

With over 34 million Americans lacking health insurance, the federal government clearly is not fulfilling its responsibility of guaranteeing access to health care for all Americans. At the same time, however, the federal government is not doing enough to assist states like Hawaii, which have not waited for Washington to act and have achieved universal health coverage through their own initiative.

The cornerstone of the health care system in Hawaii is the Hawaii Prepaid Health Care Act of 1974. Nearly two decades ago, at a time when the federal government was only beginning to wake up to the problems of our health care system, the State of Hawaii was boldly moving forward by mandating that employers provide certain basic health care benefits for their employees.

The Hawaii statute is the first and only such mandate. Over the years, the state has continued to refine and improve this system. Regrettably, the federal government has often been the greatest obstacle to allowing Hawaii to expand its system of universal health coverage.

Under the Employment Retirement Income Security Act (ERISA), states like Hawaii are precluded from imposing minimum health care requirements on employers without a specific exemption from the act. Legislation which I introduced to provide Hawaii such an exemption was enacted by Congress in 1983. Unfortunately, Congress only permitted the state to require the specific health benefits set forth in its 1974 statue.

Consequently, this landmark law has been frozen in time. In order for the Hawaii Prepaid Health Care Act to retain its limited exemption from ERISA, no substantive changes can be made in the act.

Seventeen years have passed since this legislation became law, and there is an urgent need to bring it up to date. Dependent coverage, alcohol and substance abuse treatment and the balance of premium contributions between employers and employees are major areas need to be addreesed. I have introduced a bill, S. 590, which would exclude the Hawaii health care statute from ERISA. Such an exemption would give Hawaii greater flexibility to improve both the quality and scope of health care coverage to working men and women. It would also allow the state to address inconsistencies in its innovative approach to health care.

Congress and the American public recognize that the federal government has neglected the health of millions of Americans. However, while we fashion and debate comprehensive strategies to close the nation's health care gap, we must not overlook

more modest initiatives, such as S. 590, which would allow states like Hawaii to expand innovative health care programs that have proven themselves successful.

Mr. Chairman, Hawaii's experience has much to offer in this discussion of how to reform health care. We hope we can answer some important questions and offer some solutions.

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

Thank you Mr. Chairman. Today we will hear about a critical component of our health care reform debate—State health care reform initiatives. Such approaches are critical to providing health care services to those without access to care. Given the lack of consensus on the issue of comprehensive health care reform at the Federal level, these efforts may prove essential to demonstrating successful approaches to this complex problem.

To date, most of the proposals have been employer-based. Some have proven successful, others have had problems. I believe that States should be given the opportunity to develop innovative approaches to health care delivery in their States. Toward that end, I was joined by 23 of my Republican colleagues in introducing S. 1936 in November of 1991. One component of this bill would greatly encourage state alternatives to health care reform.

S. 1936, establishes a Federal Waiver Board, made up of the Secretaries of Health and Human Services, Labor, and Veterans Affairs. States could apply for broad federal waivers of Medicare, Medicaid, Public Health Service Programs, Veterans Administration health care programs, and ERISA. The plan must provide that at least 95% of State residents have access to basic health care services and would assure that quality care was provided under the program. The Board would develop and publish three health care delivery models, from which the State could choose to establish a health care program in their state, or the State could develop an alternative model which the Board could determine meets the criteria outlined above.

I am hopeful that, with or without enactment of significant health care reform legislation this year, Congress can come to an agreement on allowing States to move forward in assuring health care services to their residents. I look forward to hearing the testimony of our witnesses. Thank you Mr. Chairman.

PREPARED STATEMENT OF GOVERNOR LAWTON CHILES

Chairman Riegle, Senator Chafee, and members of the Subcommittee. Thank you for inviting me here today to speak about our nation's pressing need for health care reform, and about the early progress we've made in Florida in attempting to work out a health care solution for our residents.

Let me begin by stressing that I share your feeling, Mr. Chairman, that national health care reform has become an absolutely essential part of the American agenda—and that the longer we delay, the more difficult it will be to come up with a solution.

As you know, I called upon Congress and the Administration to move quickly to enact comprehensive health reform legislation when the National Governors' Association met in Seattle last summer. At that time, I stated that while we would prefer a national solution to our health care cost and access problems, the States can no longer simply wait for the federal government to act.

First, I want to acknowledge that we will never—let me underscore never—resolve our national health care crisis without a national plan with national goals, standards, and objectives. In the absence of national leadership and vision, we must move ahead. For some of our citizens it is a matter of quality of life. For too many, it is a matter of life and death.

I think it is important that Congress and the Administration recognize the significant health care reforms being implemented by the states. These reforms demonstrate our willingness to tackle the twin problems of rapidly rising costs and decreasing access to care.

For this reason, I strongly support the Leahy/Pryor bill, which would give ten states the flexibility to develop different approaches to health care reform. Any comprehensive reform proposal passed by Congress should include a provision similar to the Leahy/Pryor bill, to allow states pursuing comprehensive approaches to continue down that path. If a consensus cannot be reached on a national reform plan this year, flexibility must be given to the states that are ready to pursue their own reforms.

I'd like to compliment my colleagues from Hawaii, Minnesota, Oregon, and Vermont for providing national leadership in this area. As you know, Hawaii is the only state in the country that has achieved virtually universal access to health care. Since the mid-seventies, Hawaii has had the only employer-sponsored full access system in the nation. Their commitment to universal coverage is reflected in their low infant mortality rates and the above average health status of their residents.

Minnesota and Vermont have also taken the bull by the horns and moved ahead to make sure that all of their residents have access to health care. Minnesota has done this through its Health-Right program, and Vermont has created a new health care authority to develop its plan.

Finally, Oregon has proposed an innovative approach to extend Medicaid coverage to more of its low-income, uninsured residents.

In Florida, where we have two and a half million uninsured residents, we're taking a different approach. We know that most of our uninsured residents are either workers or their family members. We also know that most Floridians prefer a largely private, employer-sponsored system of health insurance coverage. So instead of beginning by committing state government to covering all Floridians, we've issued a challenge to the private sector to solve the problem themselves.

In March I signed into law Florida's Health Care Reform Act of 1992. This legislation includes our comprehensive health care reform proposal—the Florida Health Plan—as well as a set of health insurance reforms targeted at the small employer market. Our goal is to ensure that all Floridians have access to a basic health care benefit package by December 31, 1994. Ultimately, we foresee a system in which every Floridian will have a family doctor who serves as the gatekeeper to a managed care system.

Beginning July 1st and running through the end of 1994, we'll operate a voluntary private sector health care coverage and cost containment program. The new Agency for Health Care Administration will develop targets to measure the program's success.

It surely comes as no surprise to the members of the committee that the passage of this legislation required a level of compromise and cooperation that we don't typically see. But I believe this attests to the growing sense of urgency felt by all who are concerned with health care—which includes just about everybody. The legislation enjoyed bipartisan support in both houses of the state legislature, with a total of only two negative votes. It also gained the support of a wide range of provider, employer, and consumer groups.

I have no illusions about our initial success in passing this legislation. I feel a little bit like a boxer who has won round one—with eleven more rounds to go. There are bound to be plenty of punches ahead.

We in government are going to be doing our part to help the voluntary program work. We're reforming the small group insurance market, developing a Medicaid Buy-In program, and expanding successful programs for the uninsured.

The small business insurance reforms include:

- eliminating some state benefit mandates,
- creating basic and standard benefit plans,
- requiring insurers to guarantee issuance of plans,
- prohibiting certain underwriting practices,
- implementing a 12-month limit on exclusions due to pre-existing conditions,
- eliminating denials and non-renewals on small employer plans because of health status, claims experience, occupation, or geographic location, and
- implementing restrictions on premium increases.

We're looking at ways to expand the Florida HealthAccess Program for small business employees and their families, by developing a strategy to decrease the current level of premium subsidies, improve the group's negotiating and purchasing power, and refine the use of managed care plans.

The pooled purchasing cooperative for public sector employers will expand its work with private business coalitions to get the maximum benefit from each health care dollar.

Other parts of the Florida Health Plan address additional problems in the current system. The Florida Health Services Corps will trade state-funded scholarship assistance for students in certain health professions in return for a commitment to practice in medically underserved areas. We will also establish a comprehensive health promotion program to help Floridians achieve and maintain better health—in part to promote increased personal awareness and a stronger commitment to the role of individual responsibility for good health.

In addition, I signed the Patient Self-Referral Act this year that, according to federal guidelines, specifies the narrow conditions under which physicians can refer

their patients to facilities in which they have invested. For certain facilities, such as diagnostic imaging centers, clinical laboratories, and physical and radiation therapy facilities, patient self-referrals are banned. It is estimated that these restrictions will save $200 million annually.

We must do even more. Increasing health care costs pose a serious threat to fully insuring our population and the affordability of even basic health care. I firmly believe that insuring all our citizens is the first step. By doing this, we will eliminate the cost-shifting that is undermining our private insurance system. It will also allow patients to get care when they need it, avoiding the higher costs associated with treatment delays.

At the same time, however, the public and private sectors must mount an aggressive campaign to curb health care cost increases. Florida will pursue a number of strategies, including:

- establishing statewide global expenditure limits,
- instituting tighter market entry controls,
- promoting the use of managed care,
- controlling the spread of high-tech services,
- enacting additional regulatory reforms to simplify billing, reduce insurers' overhead costs, and maximize the purchasing power of third party payers,
- implementing practice parameters to ensure the proper use of services, and
- assessing further medical malpractice reforms to reduce the insidious effects of defensive medicine.

I'm a great believer in the free market, and in the use of incentives over mandates. But if we are to provide these incentives, I need your help and additional flexibility.

We're designing a Medicaid Buy-In program for people with incomes up to 250 percent of the poverty level. To implement our buy-in program, we need Congress to remove the restrictions that tie Medicaid to other federal programs like SSI and AFDC. We also need federal matching funds to help cover working people with incomes too high to qualify under current Medicaid rules, but too low to purchase private health insurance without some government subsidy.

We need Congress to allow us to implement several other administrative efficiencies that will greatly enhance our ability to better serve Floridians and save both federal and state dollars. These initiatives include eliminating waiver requirements for:

- successfully tested home and community-based services for both the developmentally disabled and the elderly,
- expanding managed care programs, and
- developing a system of accountability that avoids the nitpicking that results from certain federal audit and documentation requirements.

With these government supports, and others we may yet develop, it is our sincere hope that the private, voluntary phase of the Florida Health Plan will achieve the goal of access to care for all Floridians by the end of 1994. But we are ever mindful of the depth and complexity of the problem, and of the failure of earlier voluntary efforts to meet the challenge. For this reason, we are also moving full-speed ahead with planning and development activities to support a second phase of the Florida Health Plan. This may involve a play or pay system—or perhaps a single-payer concept. If such intervention is required, and I truly hope that it isn't, the program will be ready for implementation in 1995.

Of course, to implement the play or pay mandate, we'd need an amendment to ERISA. We understand that there are many groups, including labor and large corporations, who want to avoid having to negotiate different insurance benefits in every state. But we feel there is room for compromise so that Florida can mandate certain benefits and experiment with an alternative payer system, yet exempt multistate employers with actuarially equivalent plans.

We clearly need the help of Congress to fully implement these reforms, but we're moving ahead as far as we possibly can without it.

At this point I'd like to submit a copy of Florida's Flexibility Proposal and a summary of the Health Care Reform Act of 1992 for the record.

Florida, along with states such as Hawaii, Minnesota, Oregon, and Vermont, has clearly not waited for a federal mandate to move ahead with health care reform. But we remain ready to work with you for change at the national level. With your help, the fourth largest state in the country is willing to try to extend the right of affordable health care to all its residents.

There is neither an easy solution, nor a single solution, and many difficult steps must be taken to recast our health care system into one that is effective, economical, and available to all.

However you proceed in your efforts, I would urge Congress to avoid a top-down approach that ignores the experience and expertise we have in state government. Under any system, states will have an important role to play in the financing and regulation of health care services. The experience we are gaining as we move ahead with our own reform efforts is a resource that you cannot afford to ignore.

Attachment.

The Florida Health Plan
Health Care Reform Act of 1992

Introduction

Approximately 2.5 million Floridians, 18.5 percent of the population, are uninsured; 75 percent are workers and their dependents; and almost one-third are children. Florida has the nation's third highest percentage of non-elderly uninsured residents. Its percentage of non-elderly uninsured is also higher than the 18.7 percent average of other Deep South States. Uninsurance is highest among blacks, males, people with incomes below $25,000, and those between the ages of 18-39. Florida also has almost 2 million residents who have incomes below the federal poverty level.

Part of Florida's high uninsurance rate can be explained by the characteristics of its business community. Large businesses are more likely to offer health insurance as a fringe benefit than small businesses. But 95 percent of Florida's businesses employ fewer than 25 people. Among firms with 5 to 9 employees, 32.3 percent are uninsured. In even smaller firms (i.e., fewer than 5 employees), 60 percent are uncovered. Workers are least likely to be insured if they are self-employed or work in agriculture, construction, retail trade, or services. However, Florida's largest industries are services and retail trade, representing almost 49 percent of the state's 1990 work force.

On March 24, 1992, Governor Chiles signed into law the Health Care Reform Act of 1992 (CS/SB 2390), legislation containing his comprehensive health care reform proposal, the Florida Health Plan, and major small business health insurance reforms. The legislation passed the Florida House of Representatives by a vote of 109 to 0 and the Senate by a vote of 35 to 2. For the first time, Florida has announced as a matter of public policy that every resident of the state will be guaranteed access to health care by December 31, 1994.

In enacting the legislation, the Florida Legislature found that:

- Health care inflation, a deteriorating health care delivery system, reduced state revenues, changing demographics, and the erosion of private health insurance have combined to create a crisis of reduced access for the poor and the uninsured.
- Access to health care is an increasing problem for many Floridians, especially women and young children, part-time employees, employees of small businesses, and the unemployed.
- The failure of Florida's health care system to be accessible to all residents is not only unacceptable to the Legislature for humanitarian reasons, but also because it results in inappropriate and far more costly use of health resources, a less productive work force, and less effective educational system.
- Almost half of the uninsured in Florida are at or near poverty, requiring insurance reforms that significantly lower costs.
- A competitive market is lacking in some areas of health care, and, therefore, an appropriate level of regulation is necessary to ensure the quality, affordability, and availability of health care services.
- The problem of health care access cannot be solved with the simple expansion of existing programs, but requires major reform of the health care delivery system.

Health Care Reform Act of 1992

The Health Care Reform Act of 1992 is a comprehensive, multi-strategy approach to health reform. The following are the major elements of the legislation:

Agency for Health Care Administration

Effective July 1, 1992, the Agency for Health Care Administration will be created. The director of Health Care Administration will report to the governor. Over a two-year period, health care financing, purchasing, planning, and health facility, professional, and cost containment regulation functions will be consolidated in the new agency. In July 1992, responsibility for the Certificate of Need program, the licensure and certification program, health planning, and the Health Care Board (health facility cost regulation) will be transferred to the new agency. In July 1993, responsibility for health professional regulation, supervision of Medicaid and State Employee Health Insurance purchasing, and contracts with the HealthAccess Corporation and the Healthcare Purchasing Cooperative will be transferred to the Agency for Health Care Administration.

The new agency will include:

- A Division of Health Quality Assurance responsible for health facility inspections and licensure, certificate of need, health professional boards, and health professional licensing.
- A Division of Health Policy and Planning responsible for the State Center for Health Statistics, development of the Florida Health plan, and other research and analysis activities. In 1993, the Division of Health Policy and Planning will assume responsibility for state health care purchasing.
- A Division of Administrative Services responsible for revenue management, budget, personnel, general services, and information systems.
- An 11-member Health Care Board appointed by the governor, including four health care providers, three representatives of businesses and industries (one with fewer than 25 employees), one representative of the insurance industry, and three consumers. The Health Care Board, a reconstituted Health Care Cost Containment Board, is responsible for hospital and nursing home budget and expenditure regulation, other health care provider data reporting, and special studies requested by the governor and the Legislature.

Voluntary Health Care Coverage and Cost Containment Program

Florida will implement a unique voluntary private health insurance coverage and cost containment program. Progressively increasing health insurance and cost containment targets will be set for the period of July 1, 1992, through December, 31, 1994, encouraging employers to offer basic health insurance to their employees and dependents. The agency is responsible for setting annual insurance coverage targets relative to the covered employee percentages and employers offering coverages by firm size and industry sector. A voluntary cost containment program during the same period will use price controls, reduced administrative overhead, and volume discounting to contain the cost of health care. If the private sector fails to meet the state-established targets, fundamental market and structural reforms, including a "play or pay" employer health insurance mandate, may be triggered in January, 1995. To promote employer coverages, the Agency for Health Care Administration will:

- identify and evaluate incentives, including tax credits, to encourage employers to provide coverage through multiple employer trusts or a state pool that purchases a private basic benefit plan for employees;
- identify and evaluate potential cost containment and quality measures, such as prevention, education, utilization review, and practice parameters; and
- identify and evaluate incentives to stimulate private health insurance companies to provide employers with affordable basic benefit coverage.

The agency must establish an advisory council of employers, providers, insurers, and consumers to provide input on the development of programs to meet the coverage and cost containment targets.

The Florida Health Plan

The Agency for Health Care Administration will be responsible for fully developing and implementing the Florida Health Plan over the next two and one-half years (July, 1992 - December, 1994). An interim implementation plan containing preliminary recommendations must be submitted to the governor and the Legislature by December 31, 1992. A final implementation plan is due December 31, 1993. The Florida Health Plan will be designed to ensure private or public health insurance coverage for all Floridians by December 31, 1994; reform the health insurance system; limit health care cost increases to manageable levels; restructure health regulation; and establish a comprehensive health care data base. The Florida Health Plan will be developed consistent with the following principles and strategies:

Health Care Access

- Ensure access to affordable basic benefits for all residents of the state regardless of health condition, age, sex, race, geographic location, employment, or economic status;
- ensure coverage of persons who are unable to obtain or afford health insurance coverage because of chronic or acute illnesses;
- distinguish the roles state and local government and employers should assume in the provision of health care services;
- ensure that by December 31, 1994, all employees and their dependents have coverage for basic health care services or mandate that employers provide such coverage;
- preclude employer-mandated coverages until state cost containment goals have been met;
- reform private health insurance practices to ensure coverage for employees and their dependents, regardless of their health status and employer size;
- provide fair reimbursement to health care providers in a timely and uncomplicated manner;
- ensure accessible health care services in rural and other medically underserved areas; and
- ensure that an appropriate number and distribution of health care facilities and health professionals are available throughout the state by January 1, 1996.

Cost Containment

- Promote the accessibility of primary and preventive care and control the proliferation of tertiary care;
- establish priorities for the use of limited resources, ensuring that higher priority is given to those programs that have been shown to produce good outcomes, secure a good value for their investment, and provide a healthy start for the state's youngest citizens;
- establish practice parameters;
- establish resource utilization systems;
- consolidate the administration of state-funded, state-administered, or state-sponsored health insurance programs;
- develop a public and private health payer mechanism to simplify billing, reduce administrative overhead costs, and maximize government and third-party purchasing power; and
- develop a system of handling medical negligence disputes that will ensure a more efficient and equitable method for determining damages and compensating injured parties.

Insurance Reforms

- Maximize employer coverage of the uninsured and ensure coverage regardless of changes in employers;
- rely on private providers for the delivery of health services;
- avoid cancellation of health insurance due to high claim costs;

- require all residents to participate in a public or private plan;
- ensure that all residents contribute, based on their ability to pay, to the financing of their health insurance;
- provide basic health insurance benefits that promote healthier lifestyles, require people to assume greater responsibility for their health, and provide early diagnosis and treatment to avoid later and more costly medical interventions;
- implement managed care in public and private health insurance plans;
- require coverage of all health risks;
- redesign market entry controls to provide uniformity across all health care providers, eliminate archaic or costly regulatory rules, limit regulation to those areas which require regulation due to limited market needs and high capitalization costs;
- provide an appropriate level of regulation in areas where market forces have been unsuccessful in constraining rapidly escalating costs; and
- eliminate laws that protect providers at public expense.

Data Collection, Research, and Analysis

- Establish a comprehensive health data system for providers, facilities, and insurers; and
- publish an annual state health expenditure report.

Governmental Contractor Health Insurance Mandate

Effective July 1, 1994, all contractors and subcontractors of state agencies with contracts in excess of $100,000 are required to ensure that their employees have access to hospitalization and medical insurance benefits during their employment on the agency contracts. The requirements do not apply to:

- contracts that are already in effect before July 1, 1994;
- blanket contracts designed to consolidate smaller contracts, provided that the ceiling does not exceed $500,000; or
- contractors or subcontractors who are subject to the provisions of a collective bargaining agreement that provides access to hospitalization and medical insurance benefits.

Practice Parameters

The law directs the Agency for Health Care Administration, in conjunction with the relevant medical associations, to guide the adoption and implementation of scientifically sound medical practice parameters to eliminate unwarranted variations in health care delivery. While adoption of the practice parameters by providers is voluntary, the agency is required to establish a demonstration project to evaluate the effectiveness of practice parameters in reducing the costs of defensive medicine and professional liability insurance.

Health Promotion Program

The law establishes a health promotion and wellness program, which will be comprehensive and community-based. The program will be designed to reduce major behavioral risk factors associated with chronic diseases, injuries and accidents, by improving individuals' knowledge, skills, and motivation to develop and maintain healthy lifestyles. The program will include conducting biennial statewide assessments of risk factors that affect residents' health; developing community-based health promotion programs; developing and implementing statewide age-, disease-, and community-specific health promotion and preventive care strategies; developing and implementing models for testing statewide health promotion programs; initiating health education programs to educate and assist the public in modifying unhealthy behaviors; and developing policies to encourage the use of alternative community delivery sites for health promotion and preventive care programs.

Florida Health Services Corps

The law creates the Florida Health Services Corps to encourage qualified medical professionals to practice in underserved locations of the state. The program is under the direction of the State Health Officer in the Department of Health and Rehabilitative Services (HRS). The program includes the following elements:

- scholarships may be awarded to students studying medicine, chiropractic, nursing, or dentistry;
- students who receive a scholarship are required to accept an assignment in a public health care program or work in a specific community located in a medically underserved area for a specified time upon graduation;
- voluntary membership in the corps may be extended to any licensed physician or other health care practitioner employed by, or under contract with, HRS who provides compensated or uncompensated care to medically indigent persons; and
- corps members are protected by the state's sovereign immunity provisions while providing uncompensated services to medically indigent persons who are referred by HRS.

Small Business Health Insurance Reforms

To improve the affordability and availability of insurance plans, several small business health insurance reforms were enacted in the Health Care Reform Act of 1992, including:

- requiring small employer carriers to offer on a guarantee-issue basis, standard and basic health benefit plans to employers with 3 to 25 employees;
- allowing the sale of limited benefit policies to small employers who reject the standard and basic plans;
- creating a Health Benefit Plan Commission to develop standard and basic health benefit plans, subject to certain mandates, which must be offered by small employer carriers;
- requiring small employer carriers to elect to become a risk-assuming carrier or a reinsuring carrier;
- establishing a reinsurance pool for risks that a carrier chooses to reinsure and establishing a premium for reinsuring risks;
- allowing a carrier to cease guarantee-issue if the carrier meets a specified cap (as an absolute cap, no carrier will be required to take over 25 percent of the small group market);
- establishing standards for the marketing of health benefit plans to small employers;
- authorizing health insurers to issue policies that provide coverage through a network of exclusive health care providers;
- requiring health insurers to give credit under pre-existing condition limitation periods for time covered under a previous group health policy;
- requiring family health insurance policies to cover dependents up to age 25 if they are living at home or are full-time or part-time students;
- requiring, upon an employer's request, that a full-time employee include any employee that works at least 25 hours per week;
- modifying 1991 legislation to close loopholes that permitted insurers to avoid limitations on small group rating practices; and
- simplifying and improving the level of benefits that must be offered to an individual who terminates group coverage, and limiting the premium to 200 percent of the standard risk rate.

Federal-State Health Care Issues
Florida's Flexibility Proposal

State of Florida
Executive Office of the Governor

April 1992

Introduction

The need to fundamentally reform our nation's health care system is finally receiving the attention it deserves. The fact that 37 million Americans lack access to a regular source of affordable medical care can no longer be ignored. In addition, escalating costs are causing people to question whether we are getting the best value for our health care dollars. Although most states would prefer a national solution to the health care crisis, they cannot wait for a consensus to develop about which strategy to pursue. If the federal government fails to enact comprehensive reform this year, it should enact legislation that encourages states to test alternative designs. To serve as laboratories in which to test alternatives, the states need flexibility from certain statutory and regulatory constraints that prevent the full implementation of comprehensive health reforms.

States that have managed to enact comprehensive health care reform legislation should not be prevented from implementing these reforms by federal laws and rules. For example, the Florida Legislature recently enacted the Health Care Reform Act of 1992, which contains sweeping plans for fundamentally changing the way health care is paid for and delivered in the state. Central to the plan is a firm deadline of December 1994 for all Floridians to have access to basic, affordable health care.

Unique population characteristics make Florida an ideal site to test health care reform. Florida has the highest percentage of elders in the nation with 18.4 percent of the population aged 65 and older. It has the third largest black population and the third highest percentage of migrants and refugees. Approximately 12 percent of the state's population is of Hispanic origin. Florida also has almost 2 million residents who live in poverty.

The nation's health care problems are magnified in Florida. Most Floridians have insurance, but 2.5 million residents, 18.5 percent of the population, are uninsured. One-third of Florida's uninsured are children. Florida has the nation's third highest percentage of non-elderly uninsured residents -- 22.9 percent. Its percentage of non-elderly uninsured in also higher than the 18.7 percent average of other Deep South states. Uninsurance is highest in Florida among blacks, males, people with incomes below $25,000, and those between the ages of 18-39.

Although the federal government should support state initiatives to provide full coverage of their citizens and operate cost-effective health care programs, it has strong interests in ensuring that states will carry out the intent of the federal programs. Florida suggests that the following general principles guide decisions on state flexibility:

- the state's health care reforms must be comprehensive, ensuring access to care for all residents by a certain date;
- the state must agree to enter into an outcome-based performance contract in exchange for being granted waivers or exemptions from federal requirements;
- benefits must include preventive and primary care in the basic plan design; and
- a state must be able to demonstrate that it has either enacted or has the support necessary to pass its health care reforms into state law.

This paper outlines the federal statutory and regulatory changes Florida needs to implement its comprehensive health care plan. It focuses on three main areas: Medicaid, Medicare, and the Employee Retirement Income Security Act. Each section reviews the issue, Florida's proposed reforms, how implementation of the proposal will help Florida achieve its health goals, and suggested measures that could be used to ensure state accountability in exchange for federal flexibility.

Medicaid

State Comprehensive Health Care Reforms

Issues

Florida's uninsured are the employees of small and medium-sized businesses that either choose not to offer coverage or cannot afford to do so because of health insurers' underwriting practices (e.g., use of preexisting condition exclusions, cancellation of policies because of claims experience, higher premiums because of the assumption of higher risks for small groups). They are disabled persons who can no longer work or who have their insurance cancelled by carriers who deem them unacceptable risks. They are people with low-incomes who do not work but are ineligible for Medicaid. Tragically, far too many are children who are denied a healthy start in life because their parents can neither afford health care nor meet eligibility requirements for publicly sponsored care.

In addition, the effects of decades of steadily rising health care costs can no longer be ignored. The Florida Medicaid budget, which has tripled in the last six years to $4.1 billion, accounted for 14 percent of the state's total budget in FY 1991-92. Conservative projections anticipate that it will triple again to $13.7 billion by FY 2000-2001. And based on the most recent four-year trend data, expenditures could conceivably reach $20 billion by 2000. Medicaid expenditure increases are now consuming virtually all new state revenues.

Florida has identified several problems with federal Medicaid statutes and regulations that prevent the states from ensuring access to health care for all their citizens, operating cost-effective programs, and implementing other comprehensive health care reforms. State efforts to cover additional low-income, unemployed or part-time workers, implement wide-scale managed care programs, and demonstrate other cost containment measures have been limited by Medicaid categorical and income limits, the linkage of federally supported public and medical assistance eligibility, managed care limitations, and federal financial participation restrictions.

Florida recently enacted the Health Care Reform Act of 1992. The legislation ensures access to basic health care for all Floridians by December 31, 1994. A voluntary coverage program will be initiated in July, 1992. This program will set progressively increasing coverage targets for employers. If employers fail to substantially meet these targets by the end of 1994, the state is prepared to implement more substantial reforms, including employer "play or pay" mandates to ensure that all citizens are ensured of basic health care coverage. To achieve full access public coverages must also be expanded to insure low-income, unemployed individuals who cannot secure health benefits from employers.

Approximately 2.5 million Floridians are uninsured; 75 percent of the uninsured are employees and their dependents; almost one-third are children. More than 600,000 uninsured persons, however, are low-income unemployed individuals who are ineligible for Medicaid. There are several federal Medicaid constraints to the full implementation of Florida's Health Care Reform Act of 1992, including improved coverages for low-income persons:

- Most of this group cannot be enrolled in Medicaid because of current eligibility restrictions. Title XIX of the Social Security Act specifies the groups that states are required to cover in their Medicaid programs. These categorical groups include aged, blind, or disabled people and members of families with dependent children. To be eligible for medical assistance, persons who are categorically eligible must also meet income, asset, and other eligibility standards for the Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC) public assistance programs. In addition, certain pregnant women, children, and Medicare-eligible individuals whose

income does not exceed certain federal poverty-related standards must also be covered. For many eligibility groups, Medicaid is tied to eligibility for economic assistance programs. Consequently, federal funding is not currently available for health care coverages for other low-income persons who are categorically ineligible for Medicaid. To some extent, the states can overcome this problem by increasing their AFDC income standards, but this requires them to provide economic benefits in order to offer medical assistance. Even then, assistance is limited to individuals who are categorically eligible. Like many other states, Florida could increase its AFDC income standards, thereby increasing federal expenditures for both economic and medical assistance. However, by decoupling economic and medical assistance income eligibility, Florida would be able to improve its health coverages without increasing federal expenditures for its economic assistance programs. In the absence of a national health plan, the federal government should encourage the states to enact comprehensive health reforms by providing matching funds needed to provide Medicaid coverage to persons who cannot obtain insurance at the workplace.

- Another aspect of the Health Care Reform Act of 1992 is an increased reliance on managed care programs for persons enrolled in publicly sponsored health plans. Although the Social Security Act permits renewable two-year freedom-of-choice waiver programs, such as Florida's primary care case management program (MediPass), regulations have significantly limited the expansion of Medicaid managed care plans. To ensure quality of care, the Social Security Act requires Medicaid HMOs and other prepaid health plans (PHPs) to maintain a 25 percent commercial (non-Medicaid, non-Medicare) enrollment. The commercial enrollment requirement, however, is a poor proxy for quality. Physicians and other providers treating Medicaid patients are often located in geographic areas other than those in which higher income, commercial enrollees live and seek care. To require that one-fourth of Medicaid PHP enrollees be commercially insured inhibits Medicaid PHP development. It also forces many Medicaid PHPs to accept high-risk commercial accounts simply to satisfy the Medicaid-commercial mix requirement, threatening the PHP's financial ability to deliver quality care. In addition, the Health Care Financing Administration (HCFA) requires states to contract for an outside evaluation of the cost-effectiveness of their freedom-of-choice waiver programs every two-year renewal period. This time frame does not provide contractors adequate time to collect sufficient data to support a meaningful assessment. In addition, it wastes state and federal funds to continue to evaluate programs that have already proven to be cost-effective.

- In July 1992, Florida will establish the Agency for Health Care Administration, a new agency consolidating health planning, regulation, and financing functions in a single agency. However, Section 1902(a)(5) of the Social Security Act requires the states to designate a single state Medicaid agency to administer or supervise the administration of the Title XIX plan. To qualify as the single state agency, the designated agency cannot delegate certain authority to other agencies to exercise administrative discretion in the administration or supervision of the plan or to issue policies, rules, and regulations on program matters. If any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other state agencies, it must ensure that its authority is not impaired. If other state or local agencies perform services for the single state agency, they must not be able to change or disapprove any administrative decision of the Medicaid agency with regard to the application of policies, rules, and regulations issued by the Medicaid agency.

- Finally, Medicaid expenditures absorb a large and increasing share of state and federal revenues. Dramatic health care cost escalation is a powerful incentive for the states and the federal government to develop cost-effective programs. State innovations that reduce program costs should be encouraged and rewarded by the federal government.

Proposal

To aid Florida and other states in implementing their comprehensive health reforms, the following modifications to federal Medicaid laws are proposed:

- Medicaid eligibility requirements should be decoupled from the eligibility requirements for other public welfare programs. Section 1902 of the Social Security Act should be amended to make federal funding available to the states to cover a new group of persons, who are Medicaid ineligible, with incomes up to a higher percentage (e.g., 250-300 percent) of the federal poverty level. Safeguards will be developed to minimize the chance of adverse selection and to initially provide these coverages to persons who are uninsured. In addition, the eligibility determination process used for this group should be simpler and faster than the present complex eligibility tests used for Medicaid categorically eligible groups. Premium cost-sharing for this group should also be allowed. Finally, the states should be permitted to develop benefit packages for this group that are less comprehensive than the federally mandated Medicaid benefit standard.

- Section 1903(m)(2)(A)(ii) of the Social Security Act should be amended, eliminating the 75/25 Medicaid-commercial enrollment requirement. States, however, should be required to establish sound PHP quality assurance programs. In addition, sections 1915(c)(9)(d) and 1915(c)(9)(c)(1) of the Social Security Act should be changed, authorizing freedom-of-choice waivers for a longer time period. Senator Moynihan has introduced legislation (S. 2077) that would make the suggested amendments to the Social Security Act.

- The federal Medicaid law should be amended to require HCFA to establish a state innovations program that requires the federal government to establish a method for calculating program savings from state innovations, and to return to the states one-half of the federal savings resulting from such innovative reimbursement, service delivery, cost containment, or other state Medicaid reforms.

- Section 1902(a)(5) of the Social Security Act should be amended, allowing states greater flexibility in structuring their health care-related state agencies. This will allow a state to design organizational structures that best meet its needs based on its unique governmental, geographic, demographic, and delivery needs.

Additional Flexibility to Aid the Implementation of Florida's Comprehensive Health Reforms

Adoption of Florida's state flexibility proposal would allow Florida to provide basic health care coverage to all its citizens as mandated by the Health Care Reform Act of 1992. It would also allow Florida and other states proposing comprehensive health reforms to serve as laboratories to test various reforms that could serve as the basis for a future national health plan. It will allow Florida and other states to expand their Medicaid coverages without increasing state and federal expenditures for economic assistance. These proposals are consistent with the principles and strategies contained in the 1992 state legislation, including the assurance of access to affordable basic benefits for residents of the state regardless of health condition, age, sex, race, geographic location, employment, or economic status; and assurance that all residents contribute, based on their ability to pay, to the financing of their health insurance.

Medicaid managed care reforms will foster the development or expansion of Medicaid PHPs, saving state and federal dollars. It will also expand Medicaid recipients' opportunities to obtain services from a PHP that offers more accessible and continuous care than is available through the fee-for-service delivery system. This proposal ensures

that the states will have even greater incentives to invest in innovations to contain program expenditures. Sharing in program savings would encourage the states to pursue additional strategies to improve care but contain costs.

Finally, providing the states with greater organizational flexibility will allow Florida and other states to design and develop health care agencies and delivery systems that are more cost-effective, and more responsive to the needs of state residents. In Florida, it will also allow the consolidation of health care-related agencies, improving the coordination of the Medicaid program with health planning and regulatory functions (e.g., control of nursing home bed supplies).

State Accountability

Social Security Act amendments authorizing greater state flexibility in designing its Medicaid program could include the following safeguards:

- require the states to continue to meet all federal service and eligibility coverage mandates for current Medicaid eligible persons;
- require the states to devote new federal Medicaid funds to provide basic health care coverage to additional persons who are currently ineligible for Medicaid;
- mandate that the states continue to monitor HMO and PHP quality of care through medical chart audits, patient satisfaction and voluntary disenrollee surveys, provider credentialing, PHP quality assurance and peer review programs, provider site visits, and other quality assurance methods;
- require the states to meet all federal Medicaid program requirements regardless of organizational alignments;
- require the states to establish health care data bases, including a federally prescribed minimum data set, that will collect needed information on health care coverages and expenditures;
- require the states to demonstrate that program reforms have not negatively affected the quality and accessibility of Medicaid services; and
- require the states to set targets for ensuring access to basic health care for all uninsured persons.

Improved Program Management

Issues

In addition to the changes that are necessary to implement comprehensive health reform proposals, there are other refinements that could be made to allow states to improve the management of their Medicaid programs. These changes would provide the flexibility states need to ensure access to care, while constraining health care costs and protecting quality of care. Congress and HCFA, in enacting federal laws and regulations, too often micromanage state Medicaid operations. The regulatory issues mentioned below are but a few of the examples of efforts by Congress and HCFA to dictate almost every facet of the operation of a state's Medicaid program. Florida proposes that Congress and HCFA generally limit their regulation to the establishment of broad parameters for state

programs (e.g., eligibility, service coverage, federal financial participation), only requiring a state to demonstrate that it has sufficient providers, adequate reimbursement, proper quality of care, and other program features to ensure that the state offers accessible, adequate care to all Medicaid eligible persons. This would require a fundamental change in federal-state relationships because HCFA would be required to prove noncompliance rather than a state proving compliance.

The Medicaid Program is a partnership between the states and the federal government to pay for health care for those Americans who are least able to afford it. Each partner pays a share of the costs and has a powerful incentive to purchase high quality care in the most cost efficient manner. The goals of the states and the federal government to ensure access to high quality, cost efficient health care are the same. Over time, however, the federal government has promulgated laws and rules that constrain and even compete with the states' abilities to achieve these goals by micromanaging the Medicaid Program. What began in 1965 as a partnership between the federal government and the states to provide health care coverage for low-income Americans has evolved into a "tops down" approach to management of the Medicaid program with the federal government issuing mandates and the states forced to comply. The following examples illustrate some of the areas in which the states need regulatory relief:

- States can obtain waivers to certain sections of the Social Security Act to operate cost-effective alternatives to the regular Medicaid program. In spite of recent efforts to streamline the waiver process, however, it takes considerable time and effort to renew regular waiver programs. Because states invest a substantial share of their own revenues in the Medicaid program, they have strong financial incentives to make sure that they operate cost-effectively. However, it literally requires "an act of Congress" to extend waiver programs beyond three years. For states that are trying to revolutionize their health systems, and incurring all the political and economic unrest associated with such a change, this is a discouraging factor. In addition, the time frame for collecting data to analyze waiver renewal requests is too short to permit a valid analysis. Judgments are made on skimpy data. Finally, renewal evaluations are required to be continued--technically every two years--for as long as the program continues successfully and is renewed by the state. This wastes scarce resources.

- To contain Medicaid acute and long-term care expenditures, the Boren Amendment was enacted, requiring the states to reimburse facilities at rates that are adequate to cover the cost of an economically and efficiently operated facility. Congress intended to create reimbursement ceilings. However, the amendment has been interpreted by HCFA and the courts in a manner that establishes a reimbursement floor, increasing state Medicaid program expenditures.

- The Social Security Act and federal regulations sometimes require the states to implement program reforms that increase costs but do not improve care. For example, OBRA 90 requires the states to cover any drug manufactured by a pharmaceutical firm if the manufacturer has signed a rebate agreement with HCFA. States should be permitted to deny reimbursement for any manufacturer's drug if other drugs in the same class of drugs are as effective but less costly. In addition, states are required to pay the Medicare Part A and Part B premiums for certain Medicare beneficiaries. As a result, the state may pay more for a beneficiary's premiums, coinsurance, and deductibles than it would have paid for total Medicaid coverage of the individual.

- States may lose valuable Medicaid matching funds for minor technical infractions which do not affect quality of care. For example, Florida recently lost a $7 million disallowance because certification staff signed ICF-DD certification forms from three to nine days late, although facility inspections had been completed on time and no threat to life or safety was found. These types of disallowances cost the state millions of dollars, reducing available funds for meeting critical state needs.

- In 1993, federal law will require that all physicians delivering services to Medicaid eligible pregnant women and children be board certified in pediatrics, family practice, or obstetrics; hold admitting privileges at a hospital participating in Medicaid; be employed by a federally qualified health center (FQHC); or be a member of the National Health Services Corps. The legislative intent is to ensure high quality care for Medicaid recipients. At best, however, the requirement is impractical because it will require a complex system for identifying and monitoring the board eligibility of physicians delivering services to pregnant women and children. At worst, it will deny payments to physicians and other practitioners who are not board-certified but are licensed by the state, further reducing recipient access to fully qualified practitioners who have chosen not to invest the time and money in seeking board certification, or for whom board certification is not applicable. To ensure good outcomes for pregnant women and their children, the states are developing complex managed care systems that use the full array of qualified practitioners. The board certification requirement will severely limit the range of providers who can serve Medicaid recipients. It also has the likelihood of disrupting the states' managed care systems, and could possibly result in poorer health outcomes.

- Each April, the states are required to submit to HCFA an amendment to their Medicaid state plans, documenting physician participation rates in the specialty areas of obstetrics and pediatrics. The plan amendment must also document physician fees for a wide array of procedure codes commonly used in the delivery of pediatric and obstetrical care. The federal requirement is intended to ensure that prenatal and child health care services are accessible and provided in a way which will reduce infant mortality and low birthweights and otherwise promote better health outcomes for infants and children. Practically speaking, however, the amendment diverts staff time from important activities that have a greater potential for achieving the desired outcomes. The inclusion of some provider types and not others as legitimate providers of obstetric and pediatric care has been a source of great debate.

Proposal

The Social Security Act should be amended to permit the states the flexibility to manage their programs in the most cost effective and efficient manner. Federal laws and regulations that seek to provide uniformity across all states may in fact inhibit them from managing their programs efficiently. The following technical changes would allow Florida to improve the administration of its Medicaid program without sacrificing high quality care for its recipients:

- Amend sections 1902(a)(13)(A), 1903(i)(13), and 1902(a)(30)(A) of the Social Security Act to (1) clarify that federal Medicaid reimbursement principles are designed to set upper reimbursement limits but permit the states to develop reimbursement methods that further control provider payments, while ensuring accessibility to and quality of care; (2) eliminate the requirement for board certified obstetricians and pediatricians; and (3) eliminate the physician participation documentation requirements.

- Amend the Social Security Act to permit states to demonstrate that alternative policies may be more cost-effective yet provide a comparable level and quality of care.

- Allow states with successful waiver programs to convert them to optional Medicaid programs that do not require waivers. Current waivers that could be authorized as optional services include programs for AIDS, developmentally disabled, and aged recipients that prevent or delay more costly institutionalization, mandatory HMO enrollment programs, and mandatory primary case management programs that emphasize preventive care.

- Allow states to establish optional services that have been successfully demonstrated in other states.

- Enact federal legislation to prohibit federal disallowances for minor technical noncompliance issues or infractions that do not involve any serious allegations of harm to patients. S. 1240 (Chafee and Riegle) could be enacted, or other legislation that amends sections 1102 and 1902(a)(4) of the Social Security Act, to ensure that states' resources are used to provide greater coverages not pay the federal government for meaningless noncompliance. This will greatly aid improved federal-state relationships.

Additional Flexibility to Aid the Implementation of Florida's Comprehensive Health Care Reforms

Current federal requirements limit state experimentation with alternative reimbursement methodologies, expanding or developing cost-effective programs, or using the most appropriate range of qualified and licensed health care professionals. The technical changes proposed in the previous section would give the Florida Medicaid program the ability to focus on the development of high quality, cost-effective programs rather than complying with bureaucratic controls that neither improve quality nor contain costs Unnecessary federal administrative requirements, such as forcing states to renew waiver programs that have already proven to be cost effective and providing documentation of access to obstetric and pediatric care, distract states from concentrating on developing strategies to achieve desired patient outcomes rather than bureaucratic controls to avoid compliance issues. To the greatest extent possible, states should be left to experiment and develop their own innovative, cost-effective programs that meet broad federal mandates.

State Accountability

In exchange for increased flexibility in the administration of its Medicaid program, Florida proposes that the following safeguards be included:

- require states to ensure that technical changes to their Medicaid programs will not have a negative impact on quality of care;

- require states to demonstrate that access to care is not limited by program changes;

- require states to show that the changes are cost-effective or budget neutral over a reasonable period of time;

- require states that convert waivered services to optional services to manage these services in accordance with federally approved state plan amendments;

- require states to conduct internal evaluations that focus on quality of care and patient outcomes rather than using reimbursement payments as a proxy for these measures;

- require states to address reimbursement levels each year to determine if rates are adequate to support high quality, accessible care;

- require states that are allowed to waive non-cost effective mandates to assure that cost effective equivalent policies are implemented;

- require states to contract with health care professionals who are qualified under state law; and

- require the states to implement state audit programs to detect federal compliance issues and implement timely corrective action.

Medicare

Issues

Medicare is a federally administered entitlement program that provides comprehensive health care benefits for elders and some disabled persons. However, current Medicare statutes only allow state administered cost control demonstrations:

- Section 402(a)(1)(A) of the Social Security Amendments of 1967 (P.L. 90-248), permits the Secretary of the Department of Health and Human Services (HHS) to experiment with alternative methods of Medicare and Medicaid reimbursement. The amendments specifically authorized incentive reimbursement demonstrations to determine if such experiments would increase the efficiency and economy of the health services covered under Medicare and Medicaid without adversely affecting the quality of services. Under Section 402(b) of the Social Security Amendments of 1967, the Secretary has broad discretion to waive Medicare and Medicaid reasonable cost and reasonable charge provisions as necessary to conduct projects under Section 402(a). Section 402(a)(1)(C) authorized state rate-setting demonstration projects, permitting Medicare and Medicaid to participate in such demonstrations and to evaluate the effectiveness of adopting a state's method of determining hospital payment levels.

- Section 222 of the Social Security Amendments of 1972 (P.L. 92-603) amended Section 402(a) of the Social Security Amendments of 1967, permitting the Secretary to waive compliance with Medicare and Medicaid payment methodologies. The 1972 amendments authorized experiments of a broad range of payment methods, including prospective reimbursement.

- In 1980, Section 1814(b)(3) was added to the Social Security Act to provide for a continuation of state hospital reimbursement demonstrations first authorized under Sections 402 and 222. However, this continuation was only permitted if the rate of increase in hospital costs per Medicare inpatient admission was equal to or less than the rate of increase for Medicare admissions to hospitals generally.

- Section 1886(c) of the Social Security Act, as guided by the Tax Equity and Fiscal Responsibility Act of 1982 (as since amended), gave the Secretary the authority to waive ordinary methods of Medicare payment and permit experimental state cost control systems for hospital reimbursement. To be eligible for waivers, states had to apply their reimbursement controls to substantially all nonfederal acute care hospitals in the state and all payers (including federal and state programs) equitably. The system must also not cost the Medicare program more money for the same hospital services.

- However, in a policy statement published in the *Federal Register* in October 1982, the Health Care Financing Administration (HCFA) indicated that, in connection with statewide hospital reimbursement demonstration projects, it was narrowing its field of interest to projects that used a diagnosis-related unit of payment. Accordingly, to be considered for approval, a demonstration project should (1) apply to all acute care hospitals in the state, (2) result in cost savings to HCFA programs, (3) use diagnosis-related groups as the unit of payment, (4) result in equal sharing of risks for all participating payers, and (5) allow HMOs to negotiate reimbursement rates with hospitals.

Under these demonstration authorities, HCFA has supported a variety of Medicare and Medicaid prospective reimbursement and rate-setting programs administered by several states. The most notable experiments using these waiver authorities were the all-payer reimbursement systems authorized in Maryland, Massachusetts, New Jersey, and New York. However, more recently HCFA has narrowed its demonstration interests, virtually ignoring the Congressionally authorized waivers to further test state cost control systems.

Proposal

Titles XVIII and XIX of the Social Security Act should be amended to permit wide-scale state administered demonstrations of alternative Medicare and Medicaid payer systems, including single payer systems for either public programs or all public and private plans; capitated and negotiated rate systems; and Medicare beneficiary managed care programs. It is possible that HHS' existing waiver authority would permit demonstration of a single payer system. However, additional statutory language is needed to specifically:

- authorize state administered demonstrations of single payer systems, including either public or public-private systems, and managed care initiatives;
- set time limits for HCFA approval of state waiver applications;
- establish federal-state risk-sharing and cost savings allocation arrangements;
- only require that state demonstrations achieve budget neutrality over a multi-year period;
- authorize longer demonstration periods (unless a national health plan is adopted) with automatic renewals for efficiently administered systems;
- permit states to consolidate Medicaid and Medicare coverages for Medicare beneficiaries; and
- permit states to offer additional Medicare benefits to contain acute and long-term care costs.

Additional Flexibility to Aid the Implementation of Florida's Comprehensive Health Reforms

Congress should authorize a new round of state administered Medicare demonstrations, including state administration of Medicare benefits through a single payer system and managed care initiatives. In enacting the Medicare and Medicaid programs, Congress chose to establish a federally administered program for the elderly and some disabled persons, but a state administered program of medical assistance for low-income families and other disabled and long-term care patients. There is no inherent reason that administration of these programs should continue in this way.

In fact, the continuation of this peculiar administration will impair implementation of Florida's comprehensive health care reforms. In many respects, Medicaid is becoming a supplemental insurance program for low-income or institutionalized Medicare beneficiaries. But the states do not have the discretion to merge Medicare and Medicaid supplemental coverages for the nation's elderly. In addition, the states are unable to maximize the value of Medicare investments by broadening long-term care coverages to include home and community-based services. Consequently, elder health reforms have lagged behind innovations for families and children because of federal Medicare administration.

Because of extraordinary increases in Medicare expenditures, state innovations in managed care and utilization control programs, and state comprehensive health care reform proposals, the federal government should authorize state demonstration to learn how to better control Medicare beneficiaries' use of services, improve the quality of needed care, and contain per capita costs. States are more knowledgeable of their populations and health care systems than the federal government is, but their unique ability to plan programs for Medicare beneficiaries that provide greater levels of service at less cost is hampered by rigid, uniform regulation.

State Accountability

Social Security Act amendments authorizing additional Medicare cost control and managed care demonstrations could include the following safeguards:

- require the states to demonstrate budget neutrality over a multi-year period, but permitting higher front-end costs offset by later year savings;
- limit federal expenditures over a multi-year period to Medicare baseline expenditures adjusted for inflation, demographic changes, and benefit package changes; however, because the state demonstrations will be highly experimental and risk-laden, the financial risk of the demonstrations should be based on Congressionally-adopted overpayment calculation formulas and equally shared by the state and the federal government up to a prescribed level above which the state would be totally responsible for cost overruns;
- prohibit state reductions of Medicare benefit levels;
- require states to share savings with the federal government;
- require states to allocate a portion of Medicare savings to enhanced benefits for Medicare beneficiaries;
- require states to demonstrate that implementation of their health care reforms has not negatively affected quality of and access to care.

Employee Retirement Income Security Act

Issues

Section 514 of the Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of employee benefit plans, including employer self-funded health insurance plans. Congress determined that the national interest required legislation to protect employee benefits. It also determined, because of the growth in the size, scope, numbers, and interstate nature of employee health benefit plans, that state regulation of benefit plans must be preempted. Advocates for continued ERISA preemption want to prevent four things: (1) state regulation of health and pension plans negotiated by management and labor; (2) state interference in collective bargaining; (3) state taxation of premiums; and (4) dilution of the pressure on Congress and the President to enact a national health plan. However, this preemption no longer serves the nation's interest. It will delay the further development and implementation of the states' comprehensive health care reforms that include universal coverage, single payer systems, "play or pay" employer mandates, and mandated benefit floors for all insurers. States failing to secure ERISA amendments may:

- implement their comprehensive health care reforms (e.g., Massachusetts), risking a likely ERISA challenge that could delay implementation for years; failure to modify the ERISA law prevents states from setting minimum mandated benefits for all residents and spreading risks equitably across all groups;
- delay implementation of health reforms, fearing litigation of more comprehensive reforms but unwilling to implement minor incremental changes; or
- abandon the employer-based, private insurance system that Americans seem to prefer and implement universal coverage programs modeled on the Canadian system, sidestepping ERISA preemptions.

Fearing employer mandates, businesses may rush to self-insure, further eroding state regulation of health insurance and preventing the universal sharing of risk that is common to most major health reform proposals.

Proposal

There are several legislative options that would provide the states with the flexibility needed to implement their health reforms:

- Repeal the ERISA preemption clause, allowing the states to fully regulate health insurance, including self-funding plans; this will permit states to regulate all insurers equally.

- Repeal the ERISA preemption for all benefit plans, except those that are negotiated by interstate employers or by national unions, but require employers with interstate agreements to demonstrate actuarial equivalency to state mandated benefits.

- Repeal the ERISA preemption clause for states that implement or have adopted in legislation a firm date for ensuring universal coverage.

- Allow the Secretary of the Department of Labor to waive statutory requirements to test ERISA-prohibited reforms, such as employer mandates and single payer systems.

Additional Flexibility to Aid the Implementation of Florida's Comprehensive Health Reforms

To ensure that all Floridians have adequate health care coverage by December, 1994, the state must have the flexibility to establish a minimum benefit package that applies to all insurance plans, commercial or self-funded, and to establish alternative payer mechanisms that supersede employer or insurer payer arrangements. If Florida is successful in securing ERISA amendments, it will be the first large state to guarantee coverage for all its citizens, establish a benefit floor for all plans, and implement other payer reforms essential to controlling health care costs.

State Accountability

ERISA amendments authorizing state regulation of self-funded health benefit plans could include the following safeguards:

- require the states to implement universal coverage programs by a prescribed date;

- require states to establish a benefit floor within broadly defined federal limits, permitting the states to negotiate their basic benefit plans with their citizens;

- require states to exempt employers with actuarially equivalent interstate health plans from state regulation; and

- require states to demonstrate that implementation of their health care reforms has not negatively affected quality of or access to care.

RESPONSES OF GOVERNOR CHILES TO QUESTIONS SUBMITTED BY SENATOR PRYOR

Question No. 1. What are frustrations that you are faced with on a daily basis in dealing with the federal regulations that we set up here in dealing with some of the areas of regulations that have really caused you some pain, and, in fact, may have ultimately caused you to deliver fewer services to the people that you represent?

Answer. The states do need some regulatory relief. First, we need relief from the often picayune nature of federal audits and disallowances in the Medicaid program. These audits cost the states millions of dollars, do not involve any serious allegations of harm to patients and seriously jeopardize a harmonious federal-state relationship.

Second, our ability to launch cost containment initiatives is severely impeded by current federal "freedom of choice" and HMO requirements. There are a host of technical issues that need remedy in the areas of demonstrations, freedom of choice and home and community-based waivers in the Medicaid program.

Third, we need to rethink several federal Medicaid requirements visited by federal law onto the states. One of these problems is the requirement that all drugs be covered for which there is a federal rebate agreement, without restriction, for the first six months of market entry.

The important point is that we need to rethink this entire Medicaid statute if we are going to let states have the flexibility to cost-effectively purchase health care for our citizens. After all, the federal government gets a larger share of the savings than the states. What we want to do is reinvest that savings by spending it on care for people who are not covered.

Fourth and finally, we need to rethink federal policy in the area of the "Qualified Medicare Beneficiary," also known as QMB. This well-intentioned federal policy, stemming from what little is left of the Medicare Catastrophic Act of 1988, is posing a large administrative and expenditure burden on the states. In Florida, we are required to pay premiums, co-insurance and deductibles for people who, in addition to having the benefit of Medicare insurance, by 1994 will have incomes up to 120 percent of poverty. In 1989 and 1990 Florida spent $20 million more on Part A premiums than it would have spent simply by paying for care outright.

Here are only a few stories that represent our health insurance crisis in Florida, they bring into focus the problems we face each day.

- A 40-year-old Miami motel maid was denied surgery at a public hospital because she could not afford a $200 deposit. She made too much money to qualify for Medicaid, too little to buy insurance, and her job did not offer an insurance plan.
- A 14-year-old Palmetto girl committed suicide after being discharged from a crisis center. Her working parents, ineligible for Medicaid, had no health insurance and could not afford the private hospitalization she needed.
- An Indialantic family is on the verge of bankruptcy with $200,000 in hospital bills for their 15-year-old daughter who has cystic fibrosis. The family's insurance company stopped writing medical policies in Florida, leaving them uncovered.
- A St. Petersburg couple's chronically ill 3-year-old daughter lost federal disability benefits and state Medicaid assistance in the months when her father received five weekly paychecks. His employer-sponsored family policy expired after his daughter received only 18 months of care.
- A Safety Harbor mother was left with $15,000 in medical bills after the birth of her baby because her employer's self-funded insurance plan ran out of money, even though she had paid over $1 in premiums during her maternity leave.
- A 61-year-old Boca Raton woman must pay $5,000 per year to Florida's high-risk pool for insurance with a $5,000 deductible. Hospitalized for months after a car crash eight years ago, she is now considered a bad risk by insurance companies, even though she is in good health and has a healthy lifestyle.

Florida's uninsured are the employees of small and medium-sized businesses that either choose not to offer coverage, or cannot afford to do so because of health insurers' underwriting practices. They are people with low-incomes who do not work but are ineligible for Medicaid. They are disabled persons who can no longer work or who have their insurance cancelled by carriers who deem them unacceptable risks. Tragically, far too many are our children who are denied a healthy start in life because their parents cannot afford health care nor meet eligibility requirements for publicly sponsored care.

Question No. 2. How many people, what resources, what manpower, or people power are employed in keeping up with the federal regulations that the state has to deal with?

Answer. Far too many staff are devoted to understanding and ensuring compliance with federal regulations rather than contributing to universal access to high quality health care. Most professional-level Medicaid employees must spend a significant portion of their time keeping up with federal regulations and determining their impact on program and fiscal operations. Some level of this activity is unavoidable in a combined federal-state program, but as the pace of health care reform has sickened, many federal regulations have become more obstructive. The fiscal impact of expanded federal Medicaid mandates is one of the primary causes of continuing budget shortfalls experienced by Florida and other states.

Virtually all health policy and planning professionals working on reform projects have been required to familiarize themselves with those aspects of Medicaid, Medicare and ERISA that effectively block a fast-track pathway to health care reform. Much time is spent developing strategies to deal with federal regulatory roadblocks—rather than designing and implementing the reform projects themselves. Florida has proposed a "Medicaid Buy-In" development project that has been partially funded by the Robert Wood Johnson Foundation. It is no exaggeration to say that a majority of the project staff's time will be spent reviewing Medicaid regulations to identify. areas where such an innovative program would be out-of-compliance with existing regulations.

RESPONSES OF GOVERNOR CHILES TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question No. 1. How will the ERISA provisions in the Leahy/Pryor bill help Florida to implement its health care reform?

Answer. To assist states in implementing their comprehensive reforms to begin correcting access and cost problems, the Leahy/Pryor bill. would give ten states the flexibility to develop different approaches to health care reform. Any comprehensive reform proposal passed by Congress should include a provision similar to the Leahy/Pryor bill, to allow states pursuing comprehensive approaches to continue down that path. If a consensus cannot be reached on a national reform plan this year, flexibility must be given to the states that are ready to pursue their own reforms.

The Florida Health Care Reform Act of 1992 requires the Agency for Health Care Administration to develop a basic benefit standard that will serve as a floor for all public and private health insurance plans. The legislation also allows the agency to begin planning for the implementation of a single or limited regional payer program and an employer play or pay health insurance mandate to be implemented in January, 1995, if the private sector fails to achieve health care coverage and cost containment targets. However, Section 514 of ERISA preempts state regulation of employee benefit plans, including employer self-funded health insurance plans. To ensure that all Floridians have adequate coverage by December 31, 1994, Florida must have the flexibility to establish a minimum benefit package that applies to all health insurance plans, commercial or self-funded, and to establish alternative payer mechanisms that supersede employer or insurer payer arrangements.

Question No. 2. If the Florida plan were enacted, what would be the impact on businesses—both those that had offered health care in the past and those who had not?

Answer. Despite opposition, employers and labor are at great risk under the current system. Although most large employers provide comprehensive health benefits to their employees, they are also paying, because of cost-shifting, for the employees of businesses that don't offer insurance. Companies that provide health benefits are at a competitive disadvantage to those that choose not to offer them. This bites into their bottom line, eroding their profits. Businesses and labor have a major stake in seeing that everyone pays a fair share for medical benefits. We feel there is room for compromise so that Florida can mandate certain. benefits and experiment with an alternative payer system, yet exempt in-state and multi-state employers with actuarially equivalent plans. Businesses already providing relatively comprehensive benefits will not be hurt by our plan.

In Florida, we're taking a somewhat different approach from the other states pursuing comprehensive reforms. We know that most Floridians prefer a largely private, employer-sponsored system of health insurance coverage. So instead of beginning by committing state government to covering all Floridians, we've issued a challenge to the private sector to work with us as a partner and develop a road map to a comprehensive solution.

We are testing this approach by creating a Voluntary Private Health Insurance and Cost Containment Program that began in July and will run through December,

1994. The state will establish health coverage and cost containment targets to measure the program's success. This critical piece of our reform effort allows the state to join with the private sector to show that a public/private partnership can solve the problems of accessibility and affordability without major government intervention.

All meaningful reform must rest on a basic foundation of support for business growth, profitable businesses, and adequately paid employees. The current erosion of wages and jobs is clearly not acceptable. Our strong support for this partnership rests on our confidence in the ingenuity of the private sector. We in government are going to be doing our part to help the partnership work. We're reforming the small group insurance market; developing a Medicaid Buy-In program; expanding successful programs for the uninsured; developing a basic benefit standard that will become the floor for all insurance plans in Florida; looking at ways to expand the Florida HealthAccess Program for small business employees and their families; and the pooled purchasing cooperative for public sector employers will extend its services to the private sector to aid them in getting the maximum benefit from each health care dollar.

Although an ERISA exemption would subject employers to state regulation like other commercial insurers, the benefits to business are often overlooked. Ultimately, business will prosper when costs and risks are spread across the entire population. State reforms permitted by an ERISA exemption will lead to improved coverages; healthier, happier, and more productive workers; lower workers' compensation costs, improved competitiveness; and greater cost control. It's not only good for the people who are currently uninsured to get health coverage, but it also makes good business sense.

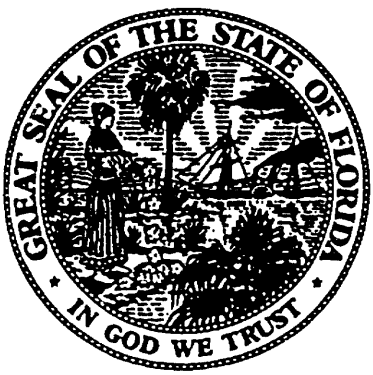
Question No. 3. What do you think is the appropriate balance between the role of the federal and state government in developing and administering a health care reform plan?

Answer. Each of the major national proposals has promising elements. But the fact that we still fall short of a broad consensus tells me that the best first step to a national reform plan is to give states the flexibility. In a couple of years we'll be able to return to you with a higher level of understanding about just what it will take to implement national health care reform. This is a workable compromise that offers the best way out of the health policy gridlock that seems to grip us so tightly.

I urge Congress to avoid a top-down approach that ignores the experience and expertise we have in state government. Under any system,states will have an important role to play in the financing and regulation of health care services. The experience we are gaining as we move ahead with our own reform efforts is a resource that you cannot afford to ignore. These reforms demonstrate our willingness to tackle the twin problems of rapidly rising costs and decreasing access to care. I believe that by granting the states additional flexibility, we will get closer to the national reforms we all want.

For more detailed information, a copy of Florida's Flexibility Proposal is attached.

Proposed Federal Statutory Changes to Aid Implementation of State Health Care Reforms: Florida's Flexibility Proposal



State of Florida
Executive Office of the Governor

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Introduction

Of the approximately 2.5 million Floridians who are uninsured, 75 percent are workers or their dependents. Florida's uninsured are the employees of small and medium-sized businesses that either choose not to offer coverage or cannot afford to do so because of health insurers' underwriting practices. They are disabled persons who can no longer work or who have had their insurance cancelled by carriers that deem them unacceptable risks. They are people with low incomes who do not work but are ineligible for Medicaid. Tragically, far too many are children who are denied a healthy start in life because their parents can neither afford health care nor meet eligibility requirements for publicly sponsored care.

The nation's health care problems are magnified in Florida. Approximately 18.5 percent of Florida's population is uninsured. Its percentage of non-elderly uninsured (22.9 percent) is the nation's third highest and is also higher than the 18.7 percent average of other Deep South states. Part of Florida's high uninsurance rate can be explained by the characteristics of its business community. Large employers are more likely to offer health insurance as a fringe benefit, but 95 percent of Florida's businesses employ fewer than 25 people. Among firms with 5 to 9 employees, 32.3 percent are uninsured. In the smallest firms (those with fewer than 5 employees), 60 percent are uncovered. Workers are least likely to be insured if they work in agriculture, construction, retail trade, or services. Florida's largest industries, however, are services and retail trade, representing almost 49 percent of the state's 1990 work force.

The state's uninsurance problem is compounded by the effects of decades of steadily rising health care costs. Total costs rose from about $9.4 billion in 1980 to $31.4 billion in 1990. During the same period, the annual premium for family coverage under the state employee health insurance program jumped from $840 to $3,756. The Florida Medicaid budget, which has increased by more than 446 percent in the last seven years to $5.4 billion, accounted for 15.7 percent of the state's total budget in FY 1992-93. Conservative projections anticipate that it will increase by another 250 percent to $13.7 billion by FY 2000-2001. And based on the most recent four-year trend data, expenditures could conceivably reach $20 billion by 2000. Publicly financed health care expenditures are now consuming virtually all new state revenues.

On March 24, 1992, Governor Lawton Chiles signed into law the Health Care Reform Act of 1992 (Chapter 92-33, Laws of Florida), legislation containing his comprehensive health care reform proposal, the Florida Health Plan, and major small business health insurance reforms. The legislation passed the Florida House of Representatives by a vote of 109 to 0 and the Senate by a vote of 35 to 2. For the first time, Florida has announced as a matter of public policy that every resident of the state will be guaranteed access to health care by December 31, 1994.

Florida will implement a unique voluntary private health care coverage and cost containment program. Progressively increasing health insurance and cost containment targets will be set for the period of July 1, 1992, through December 31, 1994, encouraging employers to offer basic health insurance to their employees and dependents and promoting cost controls by employers, providers, insurers, and consumers. The state is responsible for setting annual targets for increases in covered employees and the number of employers offering coverage by firm size and industry sector. A voluntary cost containment program during the same period will use price controls, reduced administrative overhead, and volume discounting to help contain the cost of health care. If the private sector fails to meet the state established targets, fundamental market and structural reforms, including a play or pay employer health insurance mandate and a single or limited regional payer system, may be triggered in January, 1995.

Effective July 1, 1992, the legislation established the Agency for Health Care Administration. Over a two-year period, health care financing, purchasing, planning, and health facility, professional, and cost containment regulation functions will be consolidated in the new agency. The Agency for Health Care Administration will be responsible for fully developing the Florida Health Plan over the next two and one-half years. An interim implementation plan containing preliminary recommendations must be submitted to the governor and the Legislature by December 31, 1992. A final implementation plan is due December 31, 1993. In addition to ensuring that all Floridians have access to basic health care by December 31, 1994, the Florida Health Plan will be designed to reform the health insurance system, limit health care cost increases to manageable levels, restructure health regulation, and establish a comprehensive health care data base.

Florida's Flexibility Proposal

To aid its health reform planning, particularly the expansion and improved administration of public coverages, Governor Chiles has been to Washington, D.C., several times to discuss his proposal with Congress and Bush Administration officials. He is asking for statutory and regulatory changes primarily in three areas: Medicaid, the Employee Retirement Income Security Act (ERISA) of 1974, and Medicare. In April, 1992, the Executive Office of the Governor sent a paper, *Federal-State Health Care Issues: Florida's Flexibility Proposal*, to various Congressional committees and Bush Administration officials. The paper detailed the federal statutory and regulatory changes Florida needs to fully implement the comprehensive health plan contained in the Health Care Reform Act of 1992.

Medicaid

Florida has identified several problems with federal Medicaid statutes that prevent the states from ensuring access to health care for all their residents, operating cost-effective programs, and implementing other comprehensive health reforms. State efforts to cover additional low-income, unemployed, or part-time workers, implement wide-scale managed care programs, demonstrate other cost containment measures, and organize its state agencies have been limited by Medicaid categorical and income limits; amount, duration, scope, and comparability requirements; the linkage of federally supported public and medical assistance eligibility; managed care limitations; organizational requirements; and federal financial participation restrictions.

ERISA

The Florida Health Care Reform Act of 1992 requires the Agency for Health Care Administration to develop a basic benefit standard that will serve as a floor for all public and private health insurance plans. The legislation also allows the agency to begin planning for the implementation of a single or limited regional payer program and an employer play or pay health insurance mandate to be implemented in January, 1995, if the private sector fails to achieve health care coverage and cost containment targets. However, Section 514 of ERISA preempts state regulation of employee benefit plans, including employer self-funded health insurance plans. To ensure that all Floridians have adequate coverage by December 31, 1994, Florida must have the flexibility to establish a minimum benefit package that applies to all health insurance plans, commercial or self-funded, and to establish alternative payer mechanisms that supersede employer or insurer payer arrangements.

Medicare

Florida's Health Care Reform Act of 1992 directs the Agency for Health Care Administration to develop a single payer or limited regional payer system. Florida's law also directs the agency to develop strategies to implement managed care in public and private health insurance plans. To plan for the development of a single or limited payer system and expanded managed care arrangements, Florida needs a waiver of Medicare and Medicaid administrative and reimbursement requirements.

State Leadership in Health Care Reform

In addition to the proposed Medicaid, ERISA, and Medicare statutory reforms, Florida urges Congress to recognize the significant health reforms being implemented by the states. These reforms demonstrate the states' willingness to tackle the twin problems of rapidly rising costs and decreasing access to care. In the absence of the timely enactment of a comprehensive national health plan, the Congress, as suggested by the National Governors' Association, should authorize broad state comprehensive health care reform projects, providing omnibus, one-stop federal waiver authority for state reform initiatives. Congress could limit these demonstrations to those states that have enacted legislation to provide universal or near-universal coverage.

Federal waiver authority should include:

- authority to streamline existing Medicaid and Medicare waiver processes;
- expanded waiver authority under the Social Security Act to permit greater experimentation with the Medicaid and Medicare programs; and
- authority to waive the Public Health Service Act, ERISA, the tax code, and anti-trust statutes to test other access and cost containment strategies.

Proposed Federal Statutory Reforms

Reforms Essential to the Implementation of the Florida Health Plan

The following Medicaid, ERISA, and Medicare statutory reforms are essential to fully implement the Florida Health Plan.

Medicaid

1992 Federal Legislation with a 1993-1995 Phase-In Schedule

1. Amend Sections 1902, 1905, 1906, and 1916 of the Social Security Act, authorizing a Medicaid Buy-In Program that includes persons currently ineligible for Medicaid because of categorical and income limitations. This program would eliminate the federal statutory link between Medicaid and economic assistance programs, permitting coverage of single persons, non-disabled couples with children, couples without children, and other persons with lower incomes who are currently ineligible for Medicaid. For the buy-in group, states should be permitted to waive amount, duration and scope, comparability, cost-sharing, and eligibility administration requirements. States should also be permitted to develop alternative benefit packages and increased cost-sharing requirements for buy-in eligible persons.

Florida proposes that Congress amend the Social Security Act in 1992, authorizing a phase-in of the Medicaid buy-in program according to the following schedule:

September 1, 1993 -- 100 percent of the federal poverty level

July 1, 1994 -- 150 percent of the federal poverty level

January 1, 1995 -- 250 percent of the federal poverty level

1992 Legislation with a January 1, 1993 Effective Date

1. Amend Sections 1902, 1903, and 1905 of the Social Security Act, eliminating the 25 percent commercial enrollment requirement for Medicaid-qualified prepaid health plans and permitting the states to establish primary care case management and special physician arrangement programs with expanded utilization controls.

2. Amend the Social Security law, adding a new section to the Medicaid statute, establishing a state innovations program that requires the federal government to develop a method for calculating savings from state Medicaid program innovations; and to return to the state one-half of the federal savings resulting from innovative reimbursement, service delivery, cost containment, and other program reforms.

3. Amend Section 1902 of the Social Security Act to permit states to locate Medicaid program administration and eligibility determinations in separate state agencies, providing the state with greater flexibility in structuring its health care-related state agencies.

ERISA

Florida proposes that Congress amend Section 514 of ERISA, waiving the ERISA preemption for states that have enacted comprehensive state health care reform legislation if it includes any or all of the following strategies:

- levying assessments to create statewide pooling arrangements;
- requiring employers to offer, at a minimum, a standard benefit package (as defined by the state) or pay into a public program;
- developing common administrative procedures, including, but not limited to claims forms and billing procedures;
- establishing uniform provider reimbursement rates; and
- enacting health reforms necessary to ensure universal or near-universal coverage of the state's population.

Congress should enact legislation in 1992 authorizing ERISA waivers in Florida effective January 1, 1995. The federal government would only be able to waive the ERISA preemption for Florida if the governor certifies that the goals of the Florida Health Plan, **including targets set under the state's voluntary health care coverage and cost containment program to achieve universal or near-universal coverage and substantially reduce the rate of health care cost increases, have not been met.**

Medicare

Congress should enact legislation in 1992, authorizing a new round of state-administered Medicare demonstrations, including state administration of Medicare benefits through single or limited regional payer systems. Sections 222, 402, 1814, and 1886 should be amended in 1992 to permit the state administration of the Medicare program, including operation of a single or limited regional payer systems that include administration of Medicare benefits, effective October 1, 1994. States should only be required to achieve budget neutrality over a multi-year period.

Other Reforms Needed to Contain Federal and State Health Care Expenditures

Although not essential to the implementation of the Florida Health Plan, Florida is also proposing several other Medicaid and Medicare statutory reforms that would contain costs, improve quality of care, and increase the administrative efficiency of the Medicaid and Medicare programs. The proposed Medicaid reforms should be enacted by Congress in 1992, effective January 1, 1993. The proposed Medicare reforms should also be enacted in 1992, with an effective date of October 1, 1994.

Medicaid Statutory Reforms

1. Amend Section 1915 of the Social Security Act, authorizing states with successful waiver programs, such as those for AIDS, home and community-based services, and case management, to establish long-term waiver programs or convert them to optional Medicaid services that do not require waivers.

2. Amend Section 1905 of the Social Security Act, authorizing states to establish as optional services waiver programs that have been successfully demonstrated in other states.

3. Amend Section 1915(c) of the Social Security Act, eliminating the "cold bed" factor in the determination of home and community-based service eligibility slots. Instead, federal statutes should permit home and community-based waiver slots to increase at the same rate as a state's population covered by the waiver (e.g., age 85 + population for nursing home diversion waivers).

4. Amend the Boren Amendment by modifying Section 1902(a)(13)(A) of the Social Security Act to clarify that federal Medicaid reimbursement principles are designed to set upper reimbursement limits, but permit the states to develop reimbursement methods that further control provider payments, while ensuring accessibility and quality of care.

5. Amend Section 1902(a) of the Social Security Act to permit the states to exclude drugs from its Medicaid formulary whose costs exceed a certain percentile of all drug costs in the therapeutic class if they do not offer any significant therapeutic advantage to the patient. In addition, the states should be permitted to reduce prices to drug retailers and selectively contract for drugs.

6 Amend Section 1905 of the Social Security Act to permit the states, if they determine it is cheaper than financing Medicare beneficiaries' Medicare deductibles, premiums, and copayments, to substitute state Medicaid benefits in the same amount, duration, and scope as Medicare benefits for Medicare beneficiaries who are Medicaid eligible.

7. Repeal Section 1903(i)(13) of the Social Security Act to eliminate the requirement that the states limit physician services to persons under age 21 and pregnant women to those

provided by physicians who are board certified in family practice, pediatrics, or obstetrics.

8. Amend Section 1926 of the Social Security Act to eliminate the requirement that states annually submit obstetrical and pediatric service payment rates to the Health Care Financing Administration.

9. Amend Section 1903 of the Social Security Act to prohibit federal disallowances for minor technical noncompliance issues or infractions that do not involve any serious allegations of harm to patients.

10. Amend Section 1115 of the Social Security Act to permit wide-scale, state administered demonstrations of alternative Medicare and Medicaid payer systems.

11. Amend the Social Security Act, adding a new Medicaid section that exempts states from statutory or regulatory policies that states can demonstrate are cost-promoting and, for needed policies, allows states to implement alternative policies that are more cost-effective yet provide a comparable service level and quality of care.

Medicare Statutory Reforms

Congress should also enact legislation in 1992, amending Title 18 of the Social Security Act, authorizing the states, effective October 1, 1994, to permit state administration of the Medicare program, including administration of Medicare managed care programs. States should only be required to achieve budget neutrality over a multi-year period. The waiver authority should set time limits for federal approval of state health reform waiver applications; establish federal-state risk-sharing and cost savings allocation arrangements; only require that state demonstrations achieve budget neutrality over a multi-year period; permit states to consolidate Medicare and Medicaid coverages for Medicare beneficiaries; and permit the states to offer additional Medicare benefits to contain acute and long-term care costs.

Federal and State Costs

The estimated cost of the Medicaid Buy-In Program in Florida is $53.3 million in federal fiscal year 1992-93 ($ 29.3 million in federal funds) and $742.9 million in federal fiscal 1993-94 ($408.8 million in federal funds). All other proposed statutory and regulatory reforms will enable Florida to contain federal and state health care costs. Other proposed Medicaid, ERISA, and Medicare reforms will most likely decrease the rate of federal increase in Medicaid and Medicare expenditures.

PREPARED STATEMENT OF ROBERT CRITTENDEN

Mr. Chairman, members of the committee, it is a pleasure to be here today. I am Bob Crittenden, Special Assistant for Health for Governor Booth Gardner. I am speaking on behalf of Governor Gardner today. He regrets not being able to attend this hearing, but he wants you to know that he is enthusiastic about the issues being discussed today.

Health system reform has been the major issue for Governor Gardner both as chair of the National Governors' Association and in our recent state initiatives.

Many states are developing the reforms they want to implement. Some have passed legislation and have begun the difficult work of actual reform. And, some states have put proposals forward and have not yet been successful. The state of Washington fits this latter category. There is something to be learned from all of these states.

Today I would like to speak to three very important underlying themes that should not be overlooked, and then speak to the barriers we are encountering in our reform process.

The three themes that I think you are aware of, but that I want to emphasize are:

First, states want the federal government to develop a national policy and strategy to reform the health care system.

The policy of the National Governors Association adopted unanimously last summer said, and I quote "...the nation needs to have a system that makes health care affordable and available for all Americans... "

That national policy is sadly lacking because of people who think that no policy is best. They are wrong. We are all suffering because of this inaction.

Second, states are beginning the reform process. We are not waiting for the federal stalemate to be broken.

The hypothesis that Governor Gardner espoused last year was that lacking federal action, states are compelled to begin the massive process of restructuring the health care system. Luckily this is a testable hypothesis. The people speaking to you are the tip of the iceberg of reform activity occurring in the states.

-Thirty five states have developed or are developing strategies to begin restructuring.

-More than 1[illegible] are working on massive system wide restructuring.

-Six states have legislation in place that has moved them a long way toward that goal.

These are not pilots or small projects. These are system wide reform.

Third, any national health reform will require some state specific solutions and it will require active management at the state level.

This is not a new idea, but it does need emphasizing. Many proposals by members of this body recognize the importance of restructuring that is specific to the needs of states.

New Jersey does not have the same financing system and health infrastructure as Maine or Montana. Most states have unique attitudes, problems and structures that must be considered and dealt with if health reform is to successful.

National policy must be developed and it must be cognizant of these differences.

This national policy should include goals, standards of accountability and methods of financing that encourage and enable states to appropriately restructure their systems.

Washington State:

This year Governor Gardner proposed a sweeping reform of our health care system based on recommendations of a stakeholder and citizen commission. His proposals are based on the concept of promoting multiple private integrated health systems with public oversight to assure equity, accountability and a competitive system that is required to live within fiscal limits. There are four components.

A commission was proposed that would be responsible for structuring the health system so that it is competitive and controls costs. It would determine a basic level of benefits to which all people in Washington State should have access. It would simplify the administrative burden now borne by the public and providers. It would structure the market so that there would be incentives for integrating health systems and for improving the cost effectiveness of services. It would limit the rate of inflation of health premiums.

Health insurance would be reformed so that we move aggressively towards community rating, guaranteed availability and renewability. Pre-existing limits would be almost eliminated.

Our Basic Health Plan which is a state subsidized plan for low income people would be expanded and working people could buy in at full cost.

Finally, employers would be required, over a four year phase in, to cover their workers. There would be a stop loss for small businesses so that the state would subsidize the premiums of those firms overly impacted by this new requirement.

Bills were passed out of both houses, but due to heavy lobbying from the health care industry, the majority in our Senate - controlled by a different party than ours - blocked a conference by one vote.

The people and businesses felt cheated. Polls done in conservative communities by conservative Senators strongly recorded the error of that move. The vast majority of small businesses polled by the Republican caucus of the House supported major public intervention including regulation of the health industry.

A citizens initiative has been filed.

Governor Gardner is contemplating a special session and discussions are underway.

This is a major topic of the upcoming state election and this is an issue that is certainly alive and active today.

Barriers:

There are a number of barriers that we face. I would like to outline a few.

The business community does not trust the public sector. They want effective cost control, but they are concerned that the public sector will bow to the pressures of the

health industry. They would be giving up control over their own health dollars and not control costs. This is unacceptable to them, and should be a warning to our resolve.

But, public sector activity is necessary. The business community is coming to a realization that they cannot restructure the health market without public intervention. Universal and comparable health data, simplifying the administrative nightmare, standards of practice, simplified payment methods, health insurance reform, limiting excess technology, and possibly overall budgetary limits all require an active and steadfast public sector. Even a pure Enthoven model is based on restructuring the medical market by the public sector so that systems compete on cost and quality.

The second best choice for many groups is the status quo. But, this is not a consensus process. The industry is too big and the stakes are too high. There will be losers. The enlightened part of the industry will be supporting effective reform and will be part of the debate.

Certain federal laws are both political and administrative barriers. A number of federal laws were thrown in our faces by the nay-sayers saying "even it is passed it won't be possible," or "it won't work without federal cooperation and you know how easy they make it to get exceptions."

For example - and there are more:

- o Medicare must be part of any cost containment plan. It is such a large share of the market that its inclusion in any cost containment process is essential to successful cost control.

- o ERISA is an issue. We proposed a pay or play mechanism as one method of expanding access. But, we had to compromise the policy goals to ensure we would not violate ERISA. Even so, we would have been challenged. If states are going to take the lead in expanding access, we need your help with ERISA.

- o We need to decrease the bureaucratic burden in reform - not increase it. As a method of paying for expanded access we proposed a payroll tax. Our employers already have one payroll tax - the Unemployment Insurance tax. But, because of federal rules we cannot piggyback upon that system. We would have to create a completely new and duplicative system. Our employers are correct - this is bureaucratic waste.

These barriers are political and administrative. They are in the states and they are at the federal level.

States are part of the solution.

We are working hard to develop an accepted vision, to pass needed legislation and to put together an administrative structure that improves our credibility with the private sector.

States are taking on the battles and we are on the move. You can be of great assistance by pushing reform forward at the national level, and by helping states that are the foot soldiers in this struggle.

- o Streamline the participation of federal programs in state based reform.

- o Remove the federal administrative and statutory barriers that serve the enemies of reform - not the people of this country.

- o Pass legislation that sets the standards, goals and financing of a new health system.

- Work with us to develop the infrastructure that is necessary to make the medical marketplace work.

Give us hope that the battle scars we accumulate will result in benefits for our people.

Thank you.

RESPONSES OF MR. CRITTENDEN TO QUESTIONS SUBMITTED BY SENATOR RIEGLE

Question No. 1.

- Most of the state programs discussed on this panel, with the exception of Minnesota, use the current employer-based system to expand private health care coverage.
- This is also the approach we used in HealthAmerica.

Would each of you comment on this particular model and the benefits you see from your state perspectives of this approach? Also, how important is it to have a strong cost containment program? If a strong cost containment program were to be put in place, wouldn't this help employers and make the requirement on employers less financially burdensome?

Answer. (a) An employer based system as a foundation to health care access is essential in the short run. Currently, most people in this country and our state have health coverage through their employer. It would disrupt all of those current relationships, contracts and financing to create a tax based system.

Many people in our state argue with good reason that a tax based system would be more efficient, more equitable for employees and have less impact on small employers than an employer based system. However, it is clear from evidence in Hawaii and other countries that an employer based system can improve access, be equitable and allow effective cost control.

We believe that any health care reform will be the result of many well thought out sequential steps that have the broad support of the people and interested parties. Despite its simplicity and ease of being understood, a tax based system is not well supported as a first step toward reform.

The real question is how do you build upon the employer based system. Do you mandate coverage, do you use the tax system to strongly encourage coverage (pay or play) or do you have a voluntary system with a large public subsidy for low income people. Governor Gardner believes any of these three mechanisms will get us there. The important thing is that we make a commitment and begin the process.

(b) The most important element in any health reform proposal is the mechanism to control health cost inflation. Any purchaser, employers included, would be foolish to let health inflation continue at its present rates. Employers would be better off if they could have health costs controlled, even if all uninsured were given affordable access to health coverage. The problem is that employers are split on the level of government involvement in that process. At the minimum government must have an active role in restructuring the health care market including insurance reform, definition of a minimum level of benefits, improving the health information system, simplifying and standardizing the complex administrative systems now in place, developing incentives to integrate service delivery systems and structuring payment methods so that efficiency and quality are rewarded. As the current systems have not felt compelled to compete on cost and quality, consideration must be given to a threat of more active regulation if the systems do not become more efficient.

Question No. 2.

- You have all stated that state-based reforms are not a substitute for a national solution.
- The roles of the Federal and state governments were strongly considered when we crafted HealthAmerica. We wanted to make sure there was enough flexibility at the state level to account for varying state needs and problems.

Setting aside the current Federal barriers to individual state-based reforms, what do you feel the Federal role should be in a national reform program?

Answer. The Federal rode in health care reform is necessary, but limited. As in the constitution, there are roles best done by the Federal government and there are roles best reserved to the states and the people. The Federal government role should be to ensure the principles of equity and freedom of mobility, to enable low income

and elderly people access to services and to create a financing mechanism that would be used by all states. This would include minimum standards of eligibility, benefits and portability. This would allow fairness and equity and would provide the uniformity that multi-state employers would like to have.

On the other hand, states must accept the responsibility to restructure their health delivery and financing systems so that health care costs are controlled and so that people do not face financial, geographic or other barriers to care. This will require insurance reform, expansion of access either through the employer base or through a tax financed system or both, and restructuring of the delivery systems so services are available and so that they compete on cost and quality and do, in fact, responsibly control costs.

States will need to hold the health systems accountable for the cost, quality and availability of the product they deliver to the people of their state, and the federal government must ensure that states meet the general principles determined at the federal level.

Question No. 3.

- A common provision in many of the comprehensive proposals, including our bill HealthAmerica, is a National Health Expenditure Board which would set overall spending goals for different health services and for the states.
- The Board would then convene negotiations between purchasers of health care, like unions and businesses, and providers to establish fair and reasonable payment rates for services and other mechanisms to control costs. We would also establish similar entities at the State level, so states would have the flexibility to determine their own rates as long as they stayed within the state budget goals established by the Board.

What role should the Federal government have in getting health care costs under control nationwide? How effective do you believe this model would be in reducing health care costs in the states? What is your opinion of implementing this type of *process for determining rates* where the interested parties are brought together?

Answer. This country must make a decision as to the resources it wants to put into health care. The National Health Expenditure Board could accomplish that goal. The convening of negotiations with the different interested parties would be helpful in determining overall limits and in determining payment levels and utilization controls to be used for the fee-for-service system. The incentives should be present to move people into organized delivery systems with capitated payments. Preferably, the need for negotiated payments will decrease over time.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

I am very disappointed not to be able to attend this hearing on State Health Care plans. I commend my colleague Senator Riegle for convening this hearing on a very important subject.

I am proud that my home state of Minnesota is among those states that have exercised leadership in health reform. An impressive bipartisan coalition in the state legislature worked closely with the Governor's office to pass HealthRight, Minnesota's reform bill. The Governor and his staff have made a commitment to the implementation of this reform effort.

I would also like to recognize the efforts of former Governor Rudy Perpich and Minnesota's Health Access Commission chaired by Louis Quam.

Governor Carlson has sent Curtis Johnson, his very able Senior Advisor for Health Policy, to represent my state on this issue today. I am actively working with the governor's office and the legislature to eliminate federal barriers to the new law.

Implementation of this complex, expensive, and politically sensitive legislation with be a tremendous challenge for state government, for the providers of health care, and for the patients that they serve.

Health care policy requires a healthy competitive marketplace. However, the federal and the state governments have crucial roles to play in health care access. We must strive for intergovernmental cooperation, ever sensitive to key federalism principles.

In several significant respects, the federal government stands as a roadblock to state efforts for health access reform.

On some issues, states need to get waivers from the Health Care Financing Administration in order to implement their reforms, particularly in the area of expansion of eligibility and coordination of Medicaid with new state access programs. My staff is working closely with the state of Minnesota to facilitate its efforts to receive the necessary waivers from HCFA.

There is another giant roadblock on the states' path to reform and that is the Employee Retirement Income Security Act of 1974—ERISA. In Minnesota, the capacity of the state to finance a risk pool for the uninsured has been severely handicapped because the state is barred by ERISA from seeking risk-pool financing from the large self-insured benefit plans.

Instead, the state must rely solely on premium taxes imposed on private health insurance plans sold primarily to businesses too small to self-insure and gain the portections of ERISA. With more than 60 percent of employees covered by self-insured plans, it is plain to see that the base for this tax is far too small.

In the recently enacted HealthRight access legislation, Minnesota will be relying on a hospital surtax to partially fund the program. While in principle I do not support taxes on hospitals and patients, such taxes at least indirectly require participants in self-insured plans to bear a portion of the cost of underwriting the state's access plan.

But even this approach to financing is seriously jeopardized by a recent U.S. District Court decision (*United Wire, Metal & Machine Health and Welfare Fund* v. *Morristown Memorial Hospital,* Civ. Act. No. 90–2639, May 27, 1992). The court struck down a New Jersey hosptial surcharge, the proceeds of which were used to finance uncompensated hospital care. The court ruled that the surcharge interfered with self-insured plans and union plans covered by ERISA. In fact, the opinion could be read to preclude any hospital cost-shifting that requires a self-insured plan to pay costs associated with a hospital's uncompensated care.

ERISA was adopted 18 years ago as remedial legislation aimed at protecting the pension and welfare benefits provided company employees. In the subsequent years, however, ERISA has become a shield behind which self-insured companies can avoid social responsibilities that other firms must bear.

ERISA should not stand in the way of legitimate state efforts to expand access to care. In the next few weeks, I hope to introduce legislation that will allow states to apply for federal ERISA waivers that would permit them to impose non-discriminatory surcharges on self-insured plans as part of the overall health access legislation. I hope my colleagues on both sides of the aisle will join me in this legislation so that we don't allow federal laws to impede the creative health access efforts taking place at the state level.

Ensuring that states can get waivers in order to implement health care access bills, while important, is only a short-term fix for a more fundamental problem. We need to return to fundamental principles of federalism. These principles can serve as' a guide to the appropriate allocation of responsibility among the levels of government—federal state and local—to address health care issues.

First, we must broadly define the issue—which I think should be described as public health, medical, and long term care. Public health involves health prevention and health promotion. Medical is defined as acute health care interventions by doctors, hospitals, and other health professionals. Long term care includes disability, chronic care, and care for the frail elderly.

Next, we must apply what we know about intergovernmental relations to determine what level of government can handle these components most effectively and efficiently. In my view, the principal role of the national government is in financing access to medical care for consumers; the primary role of state governments is ensuring the public health.

Long term care must be seen as two components—the acute care side which is a federal responsibility, and the housing and nurture of needy individuals which should remain a state and community responsibility.

Reallocation of responsibilities along these lines involves some significant transfers of responsibility among levels of government. I propose a swap by which the states assume responsibility for public health and, in return, the national government takes on responsibility for universal coverage of financial risk in purchasing medical care. Long term care duties would also be distributed along the lines suggested above.

As we begin this process, we must keep in mind that shifts in responsibilities among levels of government must ensure that regulatory goals and financial accountability are consonant and that the levels of government have the capacity to assume assigned responsibilities including revenue sources, planning capabilities and political will.

In the interim, there are significant opportunities for states to begin the reform process. These actions include small group insurance reform, antitrust reform, elimination of barriers to managed care, exploring models of cost controls through community planning, medical liability reform, collection of data on medical outcomes, to name just a few.

Thus, while we applaud the efforts of the states represented at this hearing, we in the national government must redouble our efforts to engage in necessary and appropriate federal reform. Most importantly, we must encourage intergovernmental communication on health care problems to begin the enormous but essential task of reallocation of responsibility for health care in America.

PREPARED STATEMENT OF CURTIS W. JOHNSTON

Mr. Chairman and members of the committee, I thank you for the opportunity to share Minnesota's experience with health care system reform.

Two months ago this week our legislature passed the law we call "HealthRight." Our law sets the stage for one state's progress in nearly every area of the national debate on health care. It is the product of an extraordinary effort to overcome ideology, partisanship, powerful interests, and general gridlock to get a bill passed. Like Washington, we have divided government, with a Republican governor and a legislature dominated by Democrats. But, we had legislative leaders whose vision of "coalition politics" rose above the usual rules of the competition; and we have a governor who simply would not settle for another, predictable standoff between a legislature's will and his veto. He showed the political courage and leadership to keep us going on the process until we produced a bill we could all support. The story about how the bill not only survived the journey through the Legislature, but actually became a better bill, is longer that this panel permits. It is a story of leadership that bridged parties and the branches of government.

HealthRight extends coverage to citizens who are systematically excluded from the health care system; it commits the state to an aggressive effort to reduce the growth rate in health care spending, while concentrating more attention on the quality of service outcomes; it responds to rural concerns about hospital closures and shortages of practitioners; it forces changes in the fairness of coverage for small employment groups.

Let me summarize briefly each of these emphases. On the "access" question, we do not claim to have revolutionized the system. We get to a form of universal coverage by concentrating on the only part of the population that the current system leaves out. These are the people we often call "the working poor." They aren't poor enough to get Medicaid, or old enough to get Medicare, or lucky enough to have employer-based coverage. They're usually working, but they don't make enough to buy coverage without help. Our law gives them that help, through a sliding-scale of premiums which reflect their ability to pay. The program emphasizes wellness and prevention in its outpatient benefits and includes limited hospitals coverage.

The centerpiece of the law is the commitment to cost containment. We are establishing the Minnesota Health Care Commission—composed of providers, employers, consumers, insurers, and union representatives—and asking it to devise a strategy that reduces the growth in health care spending while increasing the quality of care (clearly a daunting combination). The 1993 Legislature expects a report specifying how we can reduce the rate of growth in health care spending by 10 percent per year for the next five years.

I should add, parenthetically, that Minnesota already has average costs at least 15 percent below national averages. And, we are always aware that medical enterprises are Minnesota's largest business sector. We have over 500 medical technology companies, dozens of management headquarters; more population covered by HMO or managed care arrangements than all but two other states, and of course, the world renown operations of the University of Minnesota and the Mayo Clinic.

Our law requires, through the Commission, that we reach a conclusion for Minnesota on what kind of system we believe will work. We'll have advocates who prefer to move toward the single-payor, government-centered approach with all its appealing simplicities and promises of fairness. Others, especially the Governor, feel strongly that the system should rely as much as possible on private organizations, in partnership with an increasingly assertive public role. We'll have to decide where incentives can make a more functional market, and where regulation is a necessary tool.

We believe we have the commitment of our health care community to work on this challenge, and that getting them around the same table with some relaxation of the usual anti-trust barriers, we'll find creative and efficient arrangements to raise quality and control costs. We know we have the attention of our providers, since the access program is financed by a 2 percent tax on their gross revenues.

We wanted to increase the likelihood that people working for small organizations would get coverage through their employment. The law, therefore, requires carriers to offer two alternative plans which specify a more basic set of benefits than the

state's usual mandates. We require guaranteed issuance and renewability of small employer plans, and specify that participating employers must pay at least half the premium. Gender and family medical history are eliminated as underwriting criteria. The rating bands for health status, age, and geography are compressed significantly. A 12-month pre-existing condition limitation remains.

Our law reaches out to the concerns of our rural citizens. It will evaluate the fiscal status of rural hospitals, and where appropriate, provide grants. It creates a community health centers program for remote areas. It addresses the shortage of primary care physicians and other medical practitioners with incentive programs and training. Most important, it sets up boards by regions to facilitate "regional conversations" aimed at finding affordable arrangements for quality health care services in the sparsely populated parts of our state.

HealthRight also commits us to collect data about the quality and the comparative cost of medical services. These data will be used for research, for the development of practice parameters, and eventually for purchasers and consumers to use in designing incentives in benefit plans toward more efficient use of the system.

Most of Minnesota's law can be implemented within our own structures and resources. But, there are intergovernmental implications:

We will ask for the federal health insurance credit component of the Earned Income Tax Credit to be assigned to the state; and for whatever flexibility required to coordinate the provisions of our access program with Medicaid spend-down rules; and for legislation or other action clarifying the standing of our tax as a broad-based health care related tax. We will seek relief from the Medicare upper limits in implementing our own reimbursement policies for HealthRight and for Medical Assistance. We will look for the full participation of Medicare, Medicaid, veterans and other programs with the cost containment strategy we adopt.

We will want whatever approvals are needed to move Medicaid toward managed care. And, especially given the attention the recent New Jersey court decision is getting, we will argue that the federal government should grant an exemption from the federal preemption of state laws relating to health coverage under ERISA. Specifically, we are interested in the participation of self-insured companies in a broad system of payroll deductions for health coverage, and we believe the public interest suggests some extension of the state's insurance regulations to these companies.

Mr. Chairman, our request to Congress and the Administration is, essentially, to give us the flexibility to demonstrate what our state can do with this approach to health care system reform. We join the other states moving forward with bold new policies in saying: If you cannot lead on this issue, then remove the barriers that hold us back. The states will demonstrate what works and what doesn't and create a climate in which a new national policy can be adopted. Thank you.

Attachment.

HEALTHRIGHT IN MINNESOTA, MINNESOTA DEPARTMENT OF HEALTH

1. Cost Containment

Establishes the 25-member Minnesota Health Care Commission, comprised Of consumers and providers, employers, unions and state agencies to:

- set targets for reducing growth rate of health care costs by 10 percent per year for 5 years beginning in 1993, adjusted for population growth;
- monitor new technology and procedures and take into consideration clinical effectiveness, cost effectiveness, and health outcomes;
- establish locally controlled regional coordinating boards to make recommendations on ways to improve affordability, accessibility, and quality of health care in the region.

Provides antitrust protection to allow purchasers and providers to work together on cost control and sharing of resources.

Institutes uniform claim and billing forms and uniform utilization review procedures to streamline administrative efficiency and reduce costs.

Requires providers to participate in Medicaid, General Assistance Medical Care and HealthRight as a condition for participating in any state program. This will decrease the need for patients to seek more costly emergency room care because of lack of access to primary health care providers. To increase participation, reimbursement rates under most programs have been increased by 25%.

Phases in mandatory Medicare assignment to prevent providers from billing seniors more than the amount reimbursed (including co-pays) under the federal Medicare program.

Develops and implements practice parameters to avoid unnecessary and ineffective treatment and services. Compliance with these practice parameters will be considered an absolute defense as to the standard of care in malpractice cases.

Requires the collection of data on health care spending from providers and group purchasers to support practice parameters.

Requires the commissioner of health to conduct consumer education and wellness programs resulting in better informed consumers and more informed health care decisions.

Requires all providers to comply with Medicare anti-kickback provisions that prohibit financial gain from referrals or recommendations of particular procedures; grants authority to the commissioner to promulgate more restrictive rules.

Consolidates state public health programs and coordinates state health care purchasing.

Recommends moving the state toward system of managed care.

Requires the state commission to seek full time participation of federal health care programs in the state's cost containment system.

2. Insurance Reform

Small Employer Insurance Reform

Requires health carriers to offer two "small employer plans" (exempt from mandated benefits, and therefore less expensive), and makes general reforms to the small employer market.

Employer Eligibility:

- employers with 2–29 employees;
- 75 percent of eligible employees must participate in the plan;
- prohibits employer from carving out high risk employees.

Requirements of health carriers:

- must offer the two small employer plans as a condition of doing business in the small employer market;
- must guarantee issuance and renewability of small employer plans;
- must require employer contribution of at least 50 percent of the premium coverage for small employer plans;
- permits a 12 month pre-existing condition limitation, but requires credit for time covered under prior coverage (18 month limitation for late entrants);
- increases the limiting age of dependents to 25 for full-time students; and
- eliminates gender and family medical history as underwriting criteria.

Required benefits for the small employers plans are:

- one plan must pay 80 percent of charges, with a deductible of $500 per person and $1,000 per family per year;
- one plan must pay 80 percent of covered charges, with certain copayments;
- child health supervision services and prenatal care are not subject to co-insurance and deductibles. Maximum out-of-pocket costs are set at $3,000 per individual and $6,000 per family per year, and maximum lifetime benefits at $500,000.

Minimum benefits under both small employer plans are:

- inpatient and outpatient hospital services, excluding chemical dependency and mental illness;
- physician and nurse practitioner services;
- diagnostic x-rays and lab tests;
- ambulance services;
- home health care if services are payable under Medicare or are reimbursable under carrier's commonly sold plan;
- private duty nursing;
- durable medical equipment other than eyeglasses or hearing aids;
- child health supervision services;
- maternity and prenatal care services;
- inpatient and outpatient services for diagnosis and treatment of certain mental illnesses;
- 10 hours of outpatient mental health services;
- 60 hours of outpatient treatment of chemical dependency;
- 50 percent of eligible charges for prescription drugs, up to a separate maximum out-of-pocket expense of $1,000 per individual, and 100 percent of costs above $1,000.

Other Small Employer Reforms

(Applies to entire small employer market)

Requires carriers to guarantee issuance and renewability of small employer products.

Eliminates gender and family medical history as underwriting criteria.

Increases the limiting age of dependents to 25 for full-time students.

Imposes the following premium restrictions:

- variations of no more than +/− 125 percent from the index rate for health status, claims experience, industry and duration of coverage;
- variations of no more than +/− 150 percent for ages of eligible employees and dependents;
- carriers may establish three geographic regions and separate index rates for each, not varying by more than 20 percent between any two regions; and
- premiums may vary based on actuarially valid differences in benefit designs.

Reinsurance

Establishes the Health Coverage Reinsurance Corporation with membership consisting of all health care plans covering small employers.

Authorizes corporation to assess member insurers to fund the reinsurance.

An insurer may transfer up to 90 percent of the risk above $5,000 per individual; if charges exceed $50,000, insurers may transfer 100 percent of the risk. Insurers ceding individuals to reinsurance shall be assessed a reinsurance premium five times the adjusted average market price and insurers ceding entire groups to reinsurance must pay a premium one and a half times the adjusted average market price.

Private Employers Insurance Program

Vehicle by which private sector employers can pool their resources and employees to leverage greater health care purchasing power

Individual Insurance Reform

Guarantees renewability of coverage at premium not based on experience rating or medical underwriting.

Eliminates gender and family medical history as underwriting criteria.

Premium rating and restrictions are the same as those for the small employer plans.

Limits the use of pre-existing condition clauses to those in the small employer plans.

Requires that health care plans must offer individual coverage to any individual previously covered under a group.

3. HealthRight

ELIGIBILITY

- Uninsured low-income families with children and individuals will be eligible for services currently available under the Children's Health Plan, phased in as follows:
- 10–1–92: low-income families of children currently enrolled in the Children's Health Plan;
- 1–1–93: families with children up to 275 percent of poverty; and
- 1–1–94: single adults and households without children up to 275 per-cent of poverty.
- Enrollees must have been uninsured for at least 4 months, not have had access to employer-subsidized coverage for at least 18 months, and have resided in Minnesota for at least 180 days with the intent to remain permanently.
- Enrollees must be eligible for a premium subsidy to participate in the HealthRight plan; the size of the subsidy will vary according to income and family size.

4. Rural Health

Funds two grant programs to assist rural hospitals in isolated areas or in transition.

Allow's small rural hospitals to get the value of the 2 percent tax back in grants if the tax would force them to close.

Provides loan forgiveness programs to physicians, nurses, and midlevel practioners who agree to serve in rural Minnesota.

Requests the University of Minnesota to work to increase the number of graduates of residency programs of the medical school who practice primary care by 20% and to encourage these graduates to establish practices in areas of rural Minnesota.

Creates an Office of Rural Health to serve as a clearinghouse of information, coordinate the state's efforts regarding rural health, assist local communities in seeking federal or state funds, and act as an agent in the recruitment of providers to rural Minnesota.

Allows Commissioner of Health to define exemptions to anti-trust law to allow health care providers to share resources and services in rural areas when these arrangements are in the best interests of the legion.

5. Financing

Funding Mechanism

- The funding mechanism is a combination of a cigarette tax and a phased-in provider tax. Hospitals are allowed to pass this directly to consumers for one year; this funding proposal will be re-evaluated next year.
- Effective Dates:

7–1–92 to 1–1–94: 5 cent increase in cigarette tax;

1–1–93: 2 percent tax on gross patient revenues of hospitals (excludes Medical Assistance, General Assistance Medical Care, Medicare and HealthRight);

1–1–94:. 2 percent tax on gross revenues of licensed health care providers including doctors, dentists, chiropractors, etc.;

1–1–96: 1 percent premium tax on HMOS, Blue Cross, Delta and other nonprofit health service companies.

RESPONSES OF MR. JOHNSON TO QUESTIONS SUBMITTED BY SENATOR RIEGLE

Question No. 1. Most of the state programs discussed on this panel, with the exception of Minnesota, use the current employer-based system to expand private health care coverage. This is also the approach we used in HealthAmerica. Would you comment on this particular model and the benefits you see from your state perspectives of this approach? Also, how important is it to a have strong cost containment program? If a strong cost containment program were to be put in place, wouldn't this help employers and make sure the requirement on employers less financially burdensome?

Answer. The current employer-based system can be an effective vehicle for expanding access, but changes to that system need to be incorporated as part of a comprehensive strategy. Minnesota's 1992 legislation takes that approach. It focuses on employer-based coverage as the primary source of health coverage, and features several initiatives to expand access to employer-based coverage. We supplement those approaches with a state-run insurance program for those who will remain without employment-based coverage.

Minnesota's legislation requires insurers to offer small (less than 30 employees) employers several plans that will provide a basic set of benefits, but that will not cover many items that are otherwise mandated under state insurance law. We expect the newly created "small employer plans" will be less expensive than other insurance available to small employers, and will enable more small employers to enter the private market.

Our 1992 legislation also promotes employer-based coverage by creating the Private Employers Insurance Program. That program will allow small employers across the state to buy employee coverage through a purchasing pool administered by the state, so that small employers can enjoy the rate reductions and other advantages that come with volume purchasing and greater market power.

However, we expect that even with those approaches, and with several other reforms to the market (guaranteed issue and renewal, limitations on underwriting practices, many small employers will be unwilling or economically unable to provide coverage to their employees. Rather than impose employer mandates that could be extremely burdensome to small businesses, Minnesota has created a program under which families and individuals with incomes below 275% of the federal poverty level can purchase health insurance from the state, at a rate subsidized by the state. The state program includes several features to prevent erosion from the employment-based system, including a requirement that program eligibility is limited to those who have been without employment-based coverage for at least 18 months.

In response to your questions about cost containment, Minnesota agrees wholeheartedly that cost containment is a critical factor in improving access to health care. In fact, cost containment is a central focus of Minnesota's reform effort, as I outlined in my testimony.

Question No. 2. You have all stated that state-based reforms are not a substitute for a national solution. The roles of the Federal and state governments were strongly considered when we crafted HealthAmerica. We wanted to make sure there was enough flexibility at the state level to account for varying state needs and problems. Setting aside the current Federal barriers to individual state-based reforms, what do you feel the Federal role should be in a national reform program?

Answer. Market facilitator: The federal government can play an important role in collecting, analyzing and disseminating data. Reliable data would assist consumers, payors and providers in making rational, cost-effective decisions, and would thereby promote the efficient functioning of the market. This federal role would include collecting data on cost and quality, conducting outcomes research, developing and disseminating practice parameters, and studying the clinical effectiveness and cost-effectiveness of different types of health care technology. The federal government can also play a useful role by regulating entities and segments of the market that are genuinely national (such as the pharmaceutical industry).

Payor: In its capacity as a major payor for health care services (through Medicare, Medicaid, and other programs), the federal government can also work with the various states attempting to reform health care delivery in those states, and fully participate in these reform efforts. Such an approach can reduce perverse incentives in the existing system, reduce cost shifting onto the private market, and assure that complex, systemic problems can be rationally addressed in a comprehensive manner.

Much attention has been very appropriately focused on federal *barriers* (such as ERISA and the various Social Security Act provisions that prevent the use of managed care in Medicaid). But an equally serious issue is that the federal government, although a major participant in the health care market of every state, has been noticeably absent from the reform efforts of many of those states. One example of the federal role envisioned here would be for Medicare to be included within the global state health care budget or expenditure target system, and to thereby play its part along with other major purchasers in the state comprehensively reforming the state market.

Tax Law Changes: The federal government can revise the federal tax code to remove incentives to overconsume health care, and to reduce the disparate treatment of employees and the self-employed.

Public Health: Public health and prevention programs have been shown to be very cost-effective, and must be preserved and enhanced as part of any comprehensive strategy.

One approach, advocated by Senator Durenberger, would be for the federal government to leave the financing and operation of many of those programs entirely to the states, in exchange for taking over the states' responsibilities under Medicaid. Regardless of whether the federal government follows that approach, or continues the existing state/federal division of programs, it is essential that the result be that public health and prevention programs remain strong. At the most simple level, that means that programs currently funded through the Prevention Block Grant, the MCH Block Grant, and many other federal programs, be protected to the greatest extent possible from federal and state budget cuts.

Finally, I want to emphasize Minnesota's disagreement with a few of the more dramatic federal roles advocated by some, that would essentially nationalize the health care market, and direct or supervise it at the national level. It must be remembered that health care is produced and developed *locally.* Different states have dramatically different needs, resources, and markets. Delivery and payment system reforms that are developed and implemented at the federal level are unlikely to be as sensitive to these differences, or as effective, as state-based approaches.

Question No. 3. A common provision in many of the comprehensive proposals, including our bill HealthAmerica, is a National Health Expenditure Board which would set overall spending goals for different health services and for the states. The Board would then convene negotiations between purchasers of health care, like unions and businesses, and providers to establish fair and reasonable payment rates for services and other mechanisms to control costs. We would also establish similar entities at the State level, so states would have the flexibility to determine their own rates as long as they stayed within the state budget goals established by the Board. What role should the Federal government have in getting health care costs under control nationwide? How effective do you believe this model would be in reducing health care costs in the states? What is your opinion of implementing this type of *process for determining rates* where the interested parties are brought together?

Answer. As discussed in my answer to Question #2, a price-setting system driven at the federal level would not be as sensitive to the local nature of health care markets as would a more state-based system.

We do see value in designing a delivery system that encourages providers or provider networks to compete with each other on a price basis, and to encourage purchasers to be price-sensitive in their purchasing decisions. Promoting negotiations between providers and purchasers could be an important component of such a system.

Federally-set global budgets or expenditure targets for each state may have some utility. However, such an approach would be unfair and counter-productive if it were to reply on base numbers mechanically derived from current state expenditures. That type of system would punish states with more conservative health care practice styles and states that have already implemented successful cost containment measures, while doing less than is appropriate to check more bloated expenditures in other states.

PREPARED STATEMENT OF SENATOR PATRICK LEAHY

Mr. Chairman, I appreciate the opportunity to come be fore this Committee to tell you about Vermont's ambitious new law to bring health care to all Vermonters. Senator Riegle, during the development of the HealthAmerica legislation, you established a close and productive working relationship with the National Governors Association, and I know they appreciate your sensitivity to their concerns.

Today I will also describe legislation Senator Pryor and I are developing to help Vermont and other states put their comprehensive reform plans into action.

Our current health care system needs fundamental change. Skyrocketing costs are hurting families, ruining businesses and leaving millions of Americans without adequate care.

In Vermont, I recently spoke with a woman who had worked all her life. She is married with three children but faced losing her home and filing for bankruptcy because she has no health insurance to pay her hospital bills.

And I have heard from an engineer who lost his job—and then his unemployment benefits. And then he almost lost his home.

Generations of proud Vermonters—those who traditionally care for their own families—are now finding that a single illness can wipe out years of hard work and savings.

We need a comprehensive national solution to this crisis. I am working with the Majority Leader to build consensus on a comprehensive health care reform bill we can move this year—and he has my thanks for taking on this formidable task.

Our efforts are strengthened by the nation's governors who continue to push for comprehensive health care reform, both on the national and state levels. Today we will hear from two governors—Governor Chiles of Florida and Governor Waihee of Hawaii—who will tell us how they have been able to break the health care deadlock and build consensus around programs that are providing affordable care to the people of their states.

In Vermont, the momentum for health care reform has been building for a number of years. Last year, the Vermont Legislature passed the strongest small group insurance market reform law in the country.

The law, which takes effect this July, gets insurance companies back in the business of managing risk and health costs and makes health insurance available to Vermonters who have been shut out. The law bans medical underwriting and other discriminatory rating practices, and requires the use of community rating.

This year, under the strong leadership of Governor Howard Dean—the only physician governor in the country—Vermont enacted one of the most sweeping universal access plans yet. The law passed with overwhelming support from both houses of the Vermont Legislature. Many statewide organizations, including the Vermont State Medical Society, backed the plan.

The Vermont law commits the state to several key principles—global budgeting, consolidated health care regulation and administration, and the design of a universal access system. The plan is long on Yankee common sense—it emphasizes preventive and primary care so that dollars are spent wisely. And it sets a fixed, total health care budget—right up front—so that we can control costs and end cost shifting.

Mr. Chairman, I ask that a summary of the law, provided by Governor Dean's office, be made a part of the hearing record.

A newly created state health care authority will set the budget. It also will prepare detailed designs for both a single-payer and a tightly regulated multi-payer system and submit those to the Vermont Legislature next year.

Through public hearings, Vermonters will learn about and comment on the different payment systems before the Legislature begins its debate on which one is

right for Vermont. When the plan is in place by the end of 1994, all Vermonters will have access to affordable health care.

Vermont takes the first step toward universal access this July with a comprehensive health insurance program that provides coverage for children—up to age 18—living in families with incomes at or below 225 percent of poverty.

For many parents in Vermont, it will mean no longer having to make a choice between feeding their children and keeping them healthy.

What makes the Vermont approach unique—and why I think it has national application—is that it leads with cost containment. Governor Dean argued successfully for a plan that controls costs first, before the state starts putting more and more money into its health care system. So regardless of the payer system selected in 1994, the state will implement global budgeting, beginning with the adoption of nonbinding expenditure targets in 1993. In 1994, a binding, unified health care budget takes effect.

There are many tough decisions ahead for Vermonters, but there is great determination in our small state to see that everyone has affordable health care by the end of 1994.

But to succeed, Vermont and the other states courageous enough to pioneer universal health care, need federal support and involvement.

That is where the legislation I introduced last year—State Care (S. 1972)—comes in. The idea for State Care came from a town meeting two years ago when someone wondered why states couldn't come up with their own way for covering everyone and controlling costs.

It made sense to me, but what I found out is that federal laws hamper these state efforts. So the purpose of State Care is to encourage state-based comprehensive reforms by cutting federal red tape and giving states the waivers from federal requirements they need to reach their goals.

Earlier this year, my good friend David Pryor, joined me on this legislation. His knowledge and judgment have been invaluable as we have worked with many groups to refine and strengthen this legislation. I also want to recognize the constructive suggestions of Chairman Bentsen and his staff, and look forward to continuing our work together on this important initiative.

Later this summer, Senator Pryor and I will introduce new legislation that reflects these negotiations. The bill will allow up to ten states to serve as demonstration sites and will give them the flexibility to design the health care delivery system that works best for them.

States will have to put together truly comprehensive plans that assure health coverage to all residents and control overall health care costs. Our legislation will require states to achieve a significant reduction in their health care inflation rate.

A federal commission will approve, monitor and evaluate state reform initiatives. Through this commission, the waiver process for Medicaid and Medicare will be streamlined and expanded to allow greater experimentation with these programs. States must continue to provide Medicare services to the Medicare population. And they must continue to provide mandated Medicaid benefits to Medicaid recipients.

Our legislation also will grant a limited exemption from the ERISA preemption that now greatly hinders most state access and cost containment strategies. Senator Pryor and I recognize the concern any type of ERISA waiver raises, but I want to emphasize that exemptions will only be granted to the limited number of states that have enacted *comprehensive* reform initiatives.

In closing, I want to thank Senator Pryor, Governors Chiles and Waihee, and the National Governors' Association for their hard work on this legislation.

Our goal must be overhauling the nation's health care system. The pioneering efforts going on in Vermont, Florida, Hawaii, and many other states will add to the urgency for change and will show us the way.

Attachment.

VERMONT HEALTH CARE REFORM LEGISLATION

Vermont's health care reform legislation, H. 733, passed the General Assembly on April 25, 1992, with overwhelming support from both houses. H. 733 was introduced by the Speaker of the House and the House leadership of both parties. Governor Howard Dean, M. D. was the lead proponent along with a variety of statewide organizations.

H. 733 commits the state of Vermont to several key principles such as global budgeting, centralized health planning, and the design of a universal access health care system. The newly created Vermont Health Care Authority (VHCA) will prepare detailed designs for both single and multi-payer systems and submit those to the Legislature by November 1, 1993. This will be followed by extensive public education on the two proposals prior to the Legislature's deliberations beginning in January 1994. The goal is to implement universal access by October 1, 1994.

H. 733 dramatically reorders the system of health care planning, oversight and regulation in Vermont and sets the stage for implementation of more comprehensive reforms which will provide universal access to health care for all Vermonters and cost containment within two and a half years.

KEY ELEMENTS OF THE LEGISLATION:

Vermont Health Care Authority
(18 V.S.A. Sections 9403 and 9404, pages 4-6)

Creates a three person full-time health care authority appointed by the Governor. The VHCA is responsible for centralized health planning, regulation, data collection, and budgeting. The VHCA's primary task during its first sixteen months in existence is to develop two universal access designs based upon a single payer and regulated multiple payer model. The VHCA will serve as the umbrella agency over the existing Hospital Data Council, (which reviews hospital budgets) and the Health Policy Council (a broadly representative 26-member body which develops the state's health plan). The VHCA must form a Technical Review Panel consisting of medical, legal, and economic experts plus two public members to review all technical components of the universal access designs.

Universal Access Designs
(Section 2, pages 16-19)

Two plans must be submitted to the Legislature by November 1, 1993. Both designs must include the following components: oversight by one state agency, global budgeting for all health care expenditures, a uniform set of health care benefits regardless of income or employment status, centralized resource planning which controls capital expenditures and is consistent with the global budget, and portability of benefits. The bill defines the key characteristics of the single payer system, and also defines the minimum elements of the regulated multiple payer system.

Global Budget
(18 V.S.a. Section 9406, pages 6-9)

Regardless of the payer system selected in 1994, the state will implement global budgeting on an incremental basis beginning with the adoption of non-binding expenditure targets on July 1, 1993, followed by the adoption of a binding Unified Health Care Budget on July 1, 1994. The targets, and ultimately the budget, will consist of the total amount of money to be spent for all services provided by health care facilities and providers.

Provider Negotiations
(18 V.S.A. Section 9409, pages 10-11)

All provider groups, including physicians, are granted an exemption under the Sherman Anti-trust Act allowing providers to join together for the purposes of collective bargaining. Under H. 733, providers may join bargaining groups to: (1) discuss the expenditure targets with the VHCA before adoption in July 1993; (2) negotiate with the Vermont health care purchasing pool (authorized under Section 9413); and, (3)negotiate with the VHCA on the Unified Health Care budget in 1994 and annually thereafter. Nothing in H. 733 diminishes the ability of providers or facilities to negotiate contracts with insurers to the extent that it is currently permitted under law.

Health Resource Management Plan (HRMP)
(18 V.S.A. Section 9405, page 6, Section 22, pages 31-32)

Every three years the Health Policy Council (a 26 member advisory group to the VHCA) recommends a health resource management plan for adoption by the VHCA. The HRMP will be developed based upon guidelines established by the VHCA. The VHCA must hold one or more public hearings prior to adoption. The plan shall allocate resources and establish priorities for all health services in the state. It will inventory the current supply of facilities, providers, services, and technologies. The plan will determine the appropriate

supply of resources and will determine mechanisms for integration of health services at the local or regional level. In addition the plan will include a health promotion and disease prevention component prepared by the health department.

Insurance Reform
(18 V.S.A. Section 9407 and 9408, pages 9-10; Section 41 and 42, pages 48-53)

Prior to enactment of universal access in 1994, insurers will be required to foster cost containment and access by meeting the following requirements: (1) use common claims forms and uniform procedures as adopted by rule by the Commissioner of Banking, Insurance,and Securities in consultation with the VHCA effective January 15, 1993; (2) submit Health Insurer Cost Management Plans to the VHCA no later than January 15, 1993, which shall include plans for implementing "integrated systems for health care delivery"; and (3) the non-group insurance market must meet community rating and guaranteed acceptance provisions as of July 1, 1993 (similar to the provisions applicable to the small group insurance market effective in July 1992). Mandatory minimum loss ratios are also applied to the non-group insurance market. In response to the concern that community rating provisions could result in loss of insurance coverage due to rate increases or departure of insurance companies from the state, the "safety net" provisions of the bill were established which require that Blue Cross Blue Shield of Vermont provide insurance coverage to those who lose coverage at the same price and with the same coverage as the person who would otherwise receive. Other insurers, including HMOs, may participate in the safety net program if authorized by the state's Secretary of Administration.

Data Base
(18 V.S.A. Section 9410, pages 11-12)

The VHCA shall design a Unified Health Care Data Base, which will provide centralized statewide data on resources, health care needs, outcomes, and costs. Data shall be submitted by providers, insurers, facilities, and governmental bodies as required by the VHCA. This section makes it clear that physician-patient confidentiality will be protected and that the data will be used in an ethical manner.

Practice Guidelines
(18 V.S.a. Section 9411(6) page 13, and 8 V.S.A. Section 7005(b) page 59)

The first policy goal listed in the legislation is to "maintain and improve the quality of health care services offered to Vermonters." A theme throughout the bill is the establishment of "integrated systems of care" which is defined, in part, as systems which include "continuous quality improvement processes to ensure quality of care, patient satisfaction and efficiency." The bill utilizes practice guidelines as a standard of care in medical malpractice claims under the mandatory arbitration provisions in Section 46 of the bill. H. 733 also authorizes the VHCA to designate one or more organizations to make recommendations of standards of care and practice guidelines.

Primary Care and Prevention
(V.S.A. 18 Section 9411(a)(1), page 12; Section 8, page 22)

Throughout the bill references are made to strengthening Vermont's primary care network particularly in rural areas along with an emphasis upon including preventive care in a universal access design. Specifically, the VHCA is authorized to provide assistance to local communities, providers, or institutions to develop "organized primary health care systems." In addition, the University of Vermont's College of Medicine is enlisted to prepare recommendations for submission to the legislature and the VHCA in 1993 concerning initiatives to enhance the training of primary care physicians and to encourage them to locate in rural Vermont.

Certificate of Need
(Section 24-39, pages 33-47)

The CON program which regulates capital expenditures in the Vermont health care system and which is currently administered by the Health Department will now be administered by the Health Policy Council with final decisions made by the VHCA. The CON approval process must be consistent with the expenditure targets and Unified Health Care Budget, as well as with the Health Resource Management Plan.

Malpractice Reform
(Sections 46-51, pages 56-62)

Upon the effective date of universal access, all medical malpractice claims must be reviewed by an arbitration panel. The panel shall consist of a judicial referee (chair), a layperson, and a professional. The panel's decision is binding if both parties agree, or if 30 days pass after the panel's decision is issued and the case is not appealed to Superior Court. The arbitration process is to take no more than 10 months. If appealed, the panel's decision and its findings shall be admissible in the otherwise de novo appeal. The appeal may be heard by a jury. Practice guidelines may be used as the standard of care. The VHCA is instructed to

prepare a medical malpractice study due to the Legislature three years after the mandatory arbitration provisions become effective. The study shall include recommended changes to the mandatory arbitration process. In addition, if universal cost containment measures affect or place limits on clinical decision-making, then the VHCA shall recommend limitations on the liability of providers who follow practice guidelines. The VHCA must form an advisory group to advise on the study.

Vermont Health Care Purchasing Pool
(18 V.S.A. Section 9413, pages 14-16)

Effective upon passage, H. 733 requires the Secretary of Administration to establish the Vermont Health Care Purchasing Pool for the purpose of coordinating and enhancing the purchasing power of the state employees, UVM, Vermont State Colleges, municipalities, and certain portions of the Medicaid population. On or after October 1, 1993, the pool may be expanded to other employer groups such as private employers, associations, or trusts. The Secretary may enter into contracts with providers, facilities, or insurers. Providers who have joined a bargaining group may negotiate such contracts with the pool as a group.

Dr. Dynasaur
(Section 54(b), page 64)

The existing Dr. Dynasaur program which serves children up to 7 years of age living in households with incomes at 225% of poverty level (or below) is expanded to serve children up to the age of 18 using a $750,000 appropriation for FY 93.

Long-Term Care
(Section 5, pages 20-21)

The VHCA's report due to the Legislature on November 1, 1993, shall include recommendations for inclusion of long-term care services with its universal access plan. The VHCA shall estimate the costs associated with inclusion of these services and may suggest independent financing mechanisms for long-term care services. The report must include an estimate of the cost to the state over the next 20 years assuming that the current method of long-term care delivery does not change.

Appropriations and Staffing
(Section 6, pages 21-22; Section 53, pages 62-64; Section 54, page 64)

In addition to the Dr. Dynasaur Program funding, $953,000 is appropriated to the VHCA. The human resources dedicated to the VHCA include three Board members, one Executive Director, and 14 other professional and clerical staff. The VHCA may also contract for consulting and other professional services.

PREPARED STATEMENT OF JOHN C. LEWIN

INTRODUCTION

The 50th of the United States recently has become a focus of attention in national health care reform debates. In brief, the point of this paper is that Hawaii's experience is real, relevant and readily transportable. The state's approach to health care reform provides a successful implementation model that could be replicated nationwide in an appropriately modified fashion.

The paper is organized into four sections. The first describes Hawai'i's approach involving three tiers (beside Medicare)—a comprehensive Medicaid program dating from 1966, a unique mandatory employer insurance program established in 1974, and a relatively new state-subsidized insurance program that extends coverage to almost all of those outside the others. The second section documents the successes of this approach in terms of access, cost and quality. It has extended health insurance coverage almost universally, contained growth in costs to rates below national averages, and provided primary care and other system reforms that yielded improved health outcomes. The third section considers whether there may be unique conditions in Hawai'i that account for this success; it concludes that factors such as life-style, demographics and economic structure, while sometimes different in Hawai'i, do not make the state's experience an exception rather than a model. The fourth section extracts the more general lessons for the nation with respect to the design and implementation of national reforms.

The key to Hawai'i's success is both simple and at the same time profound: Hawai'i has committed itself to ensuring that quality health care is a right of all our people. Despite the fear of yet higher costs that this commitment strikes in the minds of some national policy makers, Hawai'i demonstrates that universal access

is a prerequisite to effective cost control. No other message delivered in this paper is as significant as this: the nation, learning from Hawai'i's example, must make a commitment to quality health care as a right of all citizens before it will be able to make such care affordable!

HAWAI'I'S APPROACH TO UNIVERSAL ACCESS

Hawai'i is unique among the 50 states in that it has implemented a comprehensive set of public and private programs to ensure nearly universal access. The centerpiece of the system is the Prepaid Health Care Act of 1974, which requires that all employers provide health insurance to employees working more than 19 hours per week. The triad of this employer mandate program, Medicaid, and the subsequent (1989) State Health Insurance Program (SHIP), has allowed Hawai'i to achieve near universal access.

Hawai'i's Medicaid Program

Hawai'i's Medicaid program, established in 1966, is one of the nation's most expansive. It accepts people with incomes up to 62.5 percent of the federal poverty level, compared with the average state eligibility threshold of about 45 percent of the poverty line. The state maximizes OBRA options, including pregnant women and infants to 185 percent of the poverty line, children under age 6 to 133 percent, and the elderly and disabled to 100 percent of the poverty line. Medicaid also provides coverage to general assistance recipients ineligible for federal matching funds.[1]

In total, about 89,000 people, or approximately 8 percent of Hawai'i's population, are enrolled in the Medicaid program. Medicaid beneficiaries are offered a very comprehensive benefit package, which is more expensive in per capita terms than any private health insurance offered in the state. The covered services include physician and hospital care, long term institutional care, mental health, dental, vision, prescription drugs, home health, rehabilitation, AIDS services, and medical equipment and supplies. statewide, more than 90 percent of all nursing home residents are covered by Medicaid.

Although the program, managed by the Department of Human Services, has received HCFA awards for administrative efficiency, concerns about outcomes and costs are stimulating major new partnership initiatives with the private insurance providers and the State Department of Health. These efforts will be incorporated in the overall Hawai'i health care reform agenda and be focused on managed care, utilization review, primary care and prevention incentives, and, hopefully much greater flexibility from federal requirements which disadvantage the system.

The Prepaid Health Care Act—One of a Kind

Hawai'i is the only state with a law mandating employers to provide health insurance. It is not a "play or pay" model; rather, it is an "everybody plays" approach. This is an important distinction. The law allowed Hawai'i to bring all employees into one system at one time, creating a level playing field for all businesses in a "modified" private health insurance marketplace. There is no separate government-run program for those opting to "pay" because this option does not exist. Government's only role is to guarantee that businesses comply. Thus, the Department of Labor and Industrial Relations, the-state agency which enforces the law, operates without an extensive bureaucracy. The law also contains no provisions for governmental rate-setting and leaves payment levels for services to be determined by competition in the industry.

Hawai'i is also the only state to have an "ERISA exemption," which enables the law to exist. The federal Employee Retirement Income Security Act (ERISA) preempts states from mandating health insurance coverage. Hawai'i's law was enacted just before Congress passed ERISA in 1974. However, the Prepaid Health Care Act was challenged in court by the Standard oil Company in 1976. A federal appellate court determined that the law violated ERISA; that decision was challenged, but in 1981 the Supreme Court upheld the appellate court's decision. However, in 1983, Congress reauthorized the Prepaid Health Care Act by allowing Hawai'i an exemption to ERISA. Unfortunately, the Prepaid Health Care Act, still the nation's only such ERISA exemption, has its provisions "frozen" according to what was specified in the 1974 law.

The Prepaid Health Care Act created a Premium Supplementation Fund for small businesses that can demonstrate hardship in meeting the required insurance costs for employees. This was added to allay the fears of small businesses that some could not survive with such a mandate. Ironically, the fund has been tapped only five times in 18 years for a total of $85,000. Apparently, the law has not been as difficult for business as was initially feared.

The law also created an advisory committee to assist with approval of employer health plans, and allowed for administrative penalties and judicial recourse, although rarely needed, for businesses which failed to comply. Government employees were excluded by the Act, because they already had comprehensive plans. Also excluded were approved seasonal agricultural employees, owners of small businesses, persons paid by commission, and part-time employees of less than 19 hours per week.

The standard benefit plan is extensive and includes 120 days of hospitalization, surgical and anesthesia services, comprehensive outpatient, medical and emergency coverage, maternity and well child coverage, and laboratory and radiology services. Employers in this plan are not mandated to cover dependents of employees, but, at the employee's option and with an unspecified cost-split, must extend coverage to dependents who elect coverage. There is another optional plan which employers may choose which requires a more limited yet adequate state-approved benefit package, but which requires employers to pay at least half the cost of dependent coverage. The vast majority of employers have chosen the first option, but then elected to cover dependents anyway, splitting costs with their employees. Of further interest is that 90 percent of large and small businesses have elected to add additional benefits, some of questionable value, but often including valuable benefits like dental and drug coverage.

The Act specifies how the employer-employee cost sharing occurs. The employee may be required to pay a maximum of 1.5 percent of gross monthly wages toward his or her premium, and the employer makes up the rest. The employer may not pay less than 50 percent of the employee's premium cost. Since dependents are optional under the standard plan, the cost sharing for dependents varies from business to business. Most employers give the dependents the same cost share as they extend to the employee. The average statewide cost split is estimated to be about 60 percent by employers and 40 percent by employees. As health costs increase faster than wages, employers fear that their share will grow to 80 percent unless the 1.5 percent of wages employee cost ceiling is increased by modifying the ERISA exemption.

The Hawai'i Department of Health estimates that about 87 percent of the under-65 population are covered by the employer mandate program. The majority of those covered through this Act are insured by one of two companies: the local Blue Cross/Blue Shield provider known as Hawai'i Medical Services Association (HMSA); and Kaiser-Permanente, the state's largest Health Maintenance Organization (HMO). Managed-care programs are growing and cover nearly one-third of the population but the standard fee-for-service approach is still in high demand.

A major factor in Hawai'i's success in mandating employee benefits is a voluntary system of community rating by health insurers. Experiential rating, which dominates the industry elsewhere in the nation, is not a typical practice in Hawai'i. Thus, small businesses can better predict year-to-year costs of health insurance and be guaranteed they will be able to insure their employees, even if chronically ill, Because risk and costs are pooled statewide. The law prohibits insurers from refusing an employed person—in other words, medical underwriting is prohibited. While the voluntary system of community rating is "modified," and does allow insurers to charge slightly higher rates for employers who make no effort to discourage overutilization, the community rating system has spread costs relatively evenly. As a result, Hawai'i's insurance rates for small businesses are among the lowest in the nation. For example, in 1990 the comprehensive small business plan cost $94 per month for an individual and $340 per month for a family; similar plans in California and Massachusetts cost, respectively, $141 and $217 for individual coverage, and $503 and $508 for family coverage.[2]

Hawai'i's two dominant insurers voluntarily established the modified community rating system. It appears that four factors permitted HMSA and Kaiser to maintain a modified community rating system which has, elsewhere in the nation, been abandoned in the face of experiential rating by the commercial insurers. First, HMSA and Kaiser write together the major portion of health insurance coverage in Hawai'i. With HMSA in particular, this significant market share has enabled the Blue Cross/Blue Shield insurer to negotiate effectively for efficient provider rates. Commercial competitors, with a much smaller base, are less able to negotiate similar arrangements with providers Second, the strong head-to-head competition between HMSA and Kaiser has kept rates low. Combined with large market share, this has limited the number of small businesses for whom experiential rating would result in more attractive rates. Third, both HMSA and Kaiser have low operating expenses, which also makes them more competitive than commercial insurers. Fourth, neither HMSA nor Kaiser pay commissions to agents. By doing marketing in-house, they control a significant cost item which must be borne by commercial insurers.

These factors combine to constrain significantly the competition from commercial insurers by limiting the population of businesses for whom experience-rating is financially more beneficial than contracting with "the big guys." since the small business market is risky, and not a particularly attractive market for health insurers in the first place, the major insurers have effectively competed for even this limited market by keeping costs and prices down with limited provider payments, operating efficiencies and in-house marketing agents.

The Prepaid Health Care Act facilitated this situation by assuring that all employees must be in the system and preventing healthy people from opting out. Insurers who attempted to continue to rate experientially were out-competed in the long run, leaving the two major private insurers controlling the lion's share of the employer market.

This version of community rating is an essential component of Hawai'i's employer mandate. It is necessary to guarantee reasonable rates for small businesses and to prevent the exclusion of people with health risks which otherwise render them "uninsurable" or too expensive to employ.

The State Health Insurance Program

In 1989, research conducted by the State Department of Health suggested that, despite the tremendous reduction in Hawai'i's uninsured population accomplished through the Prepaid Health Care Act and Medicaid programs, about 50,000 people or 5 percent of the population lacked health insurance. The Department further estimated that less than 35,000 of these uninsured lacked the resources to finance their health care needs. State officials then set out to cover these individuals in order to achieve the goal of universal access.

As in other states, the uninsured or a "gap" group in Hawai'i was not completely lacking in access to health care. These individuals often received ambulatory care in emergency rooms and publicly-funded clinics. They received inpatient care if they needed it and appeared as "uncompensated care" in hospital ledgers. Their emergency room and inpatient care was funded largely through cost shifting. Rather than absorb the costs of such uncompensated care, hospitals factor these costs into charges which are paid by private insurance. This process finances most of the health care received by the gap group across the nation: either the privately insured pay through hospital and emergency room rates adjusted for these uncovered costs, or the patients are shunted to public facilities, where all citizens pay through taxes. People "in the gap," however do not get primary care and preventive services. Yet, these are the services they most need, and those which would most significantly reduce the total cost of their care in the long run. For all of these reasons, the State decided to develop and implement the State Health Insurance Program (SHIP). This program was designed to emphasize primary and preventive care for people in the gap, while trying to avoid paying a second time for services which were already financed by private insurance through cost shifting.

SHIP is a public and private partnership. It is financed by state general funds with some contributions from the beneficiaries; eligibility is based on ability to pay; administration is contracted by the state to private insurance companies. There is no direct cost to business.

Since it is a "gap" program, eligibility for SHIP is restricted to those with incomes above the Medicaid threshold of 62.5 percent of the federal poverty line who are also ineligible for Prepaid Health Care. Who are they? They are either unemployed, the owners of small family businesses, part-time employed at one or more jobs, working on a contract or commission basis, or students. They also must be without insurance for three months prior to application, unless this provision is waived on the basis of medical hardship. This provision was included to avoid giving employers or employees an incentive to exclude dependents from optional coverage under Prepaid Health Care.

Further, persons whose incomes exceed 300 percent of the federal poverty threshold are not eligible, on grounds that they can afford private insurance. Members with incomes between 100 percent and 300 percent of the poverty line pay a sliding-scale share of the monthly premium; the state pays the entire premium for people with incomes below the poverty threshold. Most SHIP enrollees (86 percent of current members) have incomes below 150 percent of the poverty line. The average monthly premium contribution required of beneficiaries is less than $20 for adults and $10 for children.

The SHIP benefit package differs greatly from the employer mandate program and from Medicaid. There is coverage for prenatal and well child care, including immunizations, and age and sex-appropriate well person health appraisals, including diagnostic tests. In addition, SHIP covers 12 annual visits to physicians for symptomatic or disease-related care, again including lab and x-ray services. Emergency

room care is covered as needed, but with a $25 copayment. Other benefits include family planning services, outpatient surgery, chemotherapy and radiation therapy, antibiotics for children, and some limited mental health and substance abuse care. Hospital care is limited to five days per year, and no other catastrophic care is covered. However, patients are not actually denied necessary hospital care; instead, this care becomes either Medicaid-eligible or reverts to "uncompensated" care which, as previously mentioned, is already financed by existing hospital and insurance rates. In fact, relatively few admissions have exceeded five days, and for these most patients are expected to "spend down" to Medicaid eligibility.

SHIP members pay a $5 copayment for outpatient visits, except for preventive care, and a $25 copayment for emergency room visits. SHIP began with discounted physician payments to save money, but found that the feared cost overruns for the program did not occur, and payment levels now are set to equal private insurance rates.

The eligibility paperwork for SHIP is simple, without the asset requirements of Medicaid. Applications are accepted statewide at Department of Health offices and at private facilities. Claims forms are the same as for private insurance. Insurance is offered to eligibles by both HMSA and Kaiser-Permanente. In addition, special contract arrangements are being developed between SHIP and various community health centers to deal with special populations which are difficult to insure because of homelessness, mental illness, substance abuse, or cultural barriers.

SHIP was approved by the Legislature in 1989 and began enrolling clients in mid-1990. In 1992 enrollment has reached 17,000, with an average annual cost of about $600 per beneficiary. Most of the beneficiaries are young, working parents and their children; fully 83 percent are less than 44 years old and 43 percent are under age 18.

A final important point to make about SHIP is that it was judged affordable by the citizens and legislators of Hawai'i because it was preceded by the employer mandate. That is, the gap group remaining to be covered by SHIP was smaller than in other states because most of the previously uninsured had already benefited from the 1974 Prepaid Health Care Act. Estimates are that the employer mandate reduced the share of the population remaining uninsured from about 17 percent in 1974[3] to 5 percent in 1989.[4] It was only this smaller group that SHIP must finance.

States without an employer mandate will find it much more difficult fiscally to move directly to a tax-financed program for the uninsured. Washington State's "Basic Health" program illustrates this point. This highly-regarded program is similar to SHIP in that it focuses on insuring the state's gap groups but it appears that Washington can afford to reach only about 10 percent of the large, mostly-employed group of eligibles. This access problem will not be solved exclusively with state funds; employers will also have to be obliged to pay a share.

SHIP, then, joins the Prepaid Health Act and Medicaid to complete Hawai'i's universal access triad. Its immediate future is positive. But questions arise about SHIP's long-term future. Should it merge with Medicaid into a partnerSHIP? Will SHIP continue to be necessary if the health care reforms plans of Hawai'i are realized?

The answers to such questions depend heavily on the federal government's eventual approach to health care reform. But it is important to recognize that, regardless of these concerns for the future, SHIP is an irreversible step in the right direction. The recipients are people who previously lacked access to primary and preventive health care services, which they now receive. No well-conceived future plan could take such services away from these individuals. Rather, as health care reform takes shape nationally, Hawai'i's leaders hope that SHIP will expand and blend into a seamless system off consistent, coordinated and universal access.

HOW WELL DOES HAWAI'I'S SYSTEM WORK?

National health policy experts visiting Hawai'i might expect local euphoria about the health care system. Instead, they discover that most residents are unaware of their relative good fortune; they find that physicians and hospitals are outraged by low reimbursements and increasing paperwork associated with Medicare and Medicaid; they hear small businesses bemoaning government's mandating of employee coverage as unfair and financially' strapping. While these observations are not universal, such comments are too often mistaken by outside analysts and observers as evidence that no real progress has been made in Hawai'i.

Let's face it, insurers, physicians, legislators, hospitals, public health leaders, businesses, and the mushrooming numbers of those claiming to be Hawai'i "experts" do not share consistent views of the strengths and weaknesses off the system. Nor do they agree on which factors and/or parties are responsible for either the successes

in access or the recent experience with rising costs. Rather, like their counterparts elsewhere, each off these groups has a "vantage point" with which a significant amount off proprietary vesting is involved.

Nonetheless, it is possible to construct a general, if less than crystal clear, picture off how Hawai'i's system is actually working. There are four points of general consensus. First, Hawai'i has the best overall access to care in the nation. Second, the quality off health care in Hawai'i is high. Third, Hawai'i has health care costs which are significantly lower than in other states, which is remarkable in view off Hawai'i's generally high costs off living, the presence off significant social ills and at-risk populations, and its access achievements. Finally, Hawai'i is the healthiest state in terms of longevity, infant mortality, and premature morbidity and mortality rates for heart disease, cancer, and emphysema.

Access to Care

In terms of access to care, Hawai'i is as close to being universally insured as any state is likely to come. Nearly every citizen under age 65 is eligible for insurance under Prepaid Health Care, Medicaid or SHIP. (The VA and CHAMPUS provide additional coverage for some residents.) Senior citizens enjoy Medicare benefits and have either a retirement-related policy extending employment benefits or Medicaid to supplement shortfalls in Medicare coverage.

The few remaining uninsured fall into two groups: those who have not or will not present themselves for coverage; and those who are affluent enough to purchase coverage, but choose instead to pay cash for services and risk their assets to the potential off a catastrophic illness.

The first remaining group of uninsured are eligible for Medicaid or SHIP, but are "diffficult-to-insure" because they are home less, mentally ill, chronic substance-abusers, illegal immigrants, or face cultural barriers to care. The number off such people is estimated by the Department off Health to be less than 20,000. They most often receive episodic care from community health centers or public clinics. They are not denied hospital care when they need it. There will always be such a residual population which requires special outreach and coverage in any version of health care reform developed; and many of these individuals will also require c mmunity-based social services that will best be provided outside of the traditional health delivery system through a public health network of coordinated care.

The relatively affluent people who have elected not to purchase insurance are estimated to comprise about 1 or 2 percent of the population. Most are young, self-employed, or even newly graduated physicians and attorneys. These people may feel immortal at this point in their lives, but will eventually choose to purchase insurance after marriage, having children, acquiring sufficient assets to fear losing, or experiencing the costs off care with an episodic illness or injury. In any case, these people should not be considered as lacking access.

Probably the most significant lesson from Hawai'i's experience is that an employer mandate is an effective tool for achieving universal access. The "everybody plays" approach is superior to the "play or pay" approach. The "play or pay" model will directly or indirectly shift control to government and thereby discourage innovation in the delivery system, as well as reduce consumer choice and provider satisfaction. In contrast, the "everybody plays" approach provides a "level playing field" for all businesses, while ensuring a strong package off benefits for all. Most significantly, it accomplishes this without government rate setting or other financial controls. Employers must provide specified coverage, but they are allowed flexibility to determine how it is provided. Under this system, business does what business does best—it finds the most cost effective way to provide health care—or at least it tries to do so.

Perhaps the greatest long-term impact on access is that employers have been prevented from dropping employees as rates have increased. When the law was passed in 1974, insurance costs were relatively low. Average health insurance rates increased six-fold nationally from 1975 to 1990.[6] At the same time, medical care as a percentage of disposable income for individuals nationally rose from 8.5 percent to 13.6 percent.[6]

If not for the mandatory coverage, many people in Hawai'i would have been dropped as cost pressures increased for employers. This would have increased uncompensated care and—due to cost-shifting—insurance costs for large businesses. The Hawai'i Healthcare association reports that Hawai'i's relatively modest hospital cost-shifting relates mainly to Medicaid and Medicare, and is at modest rates compared to the rest of the nation. They attribute this difference to advantages of the Prepaid Health Care Act.[7]

Finally, the employer mandate has improved and maintained access through its required standard off benefits. Employees were guaranteed good coverage, and in-

surers had to compete fairly. Many mainland commercial plans are marginal, or contain high co-payments and deductibles, which, in essence, discourage access, especially to primary care and preventive services. In contrast, commercial companies competing in Hawai'i must increase their benefits at least to the law's standards. In addition, HMSA and Kaiser do not screen out people on the basis of medical history. This has become such standard practice, by virtue of market competition and public expectation that, for all practical purposes, the law has eliminated these adverse practices.

Quality and the Emphasis on Primary Care

In terms of quality, Hawai'i's health care system is excellent. The state's high standards are reflected in JCAHO accreditation of facilities; in excellent Medicare comparative evaluations; in generous amounts of high-tech medical technologies and related tertiary care services; and, except in a few rural areas, in high levels of consumer and provider satisfaction. With respect to premature morbidity and mortality, Hawai'i performs exceptionally well. With respect to Hawai'i has the greatest longevity of any state, with females living to nearly 84, and males to nearly 80 years. These numbers are higher than Japan's. Hawai'i usually ranks the lowest (best) in cardiovascular disease, cancer, emphysema and pulmonary disease. Its infant mortality rates werel with Vermont, the lowest in the nation in 1990. The Northwest Life Insurance Company 1991 rankings for states place Hawai'i as the healthiest state overall.

However, Hawai'i shares with the rest off the nation the quality concern that too much medical care is provided to too many patients, too often. Stated differently, Hawai'i and the rest of America have considerable room for improvement in the efficient allocation of expensive medical technology. While Hawai'i is more efficient than some regions of the country, it could reduce inpatient costs even further, par ticularly through the reduction of unnecessary diagnostic testing, medication, surgery and defensive actions based on physician fears of malpractice litigation. It also could make further progress in the quest to eliminate the use of an emergency room as a primary care "medical home" in rural areas lacking sufficient providers.

In this latter area, Hawai'i's system of universal access has extended outpatient care in a "medical home" setting to almost all the population. People do not choose expensive emergency settings if they have good primary care options, and soon nearly everyone, even in remote areas, will have that choice in the Aloha State.

Hawai'i's low rates of premature morbidity and mortality, and its low overall costs arguably are attributable to the greater access to pre-hospital and primary care, compared to other parts of the nation. This point may be debated, but significant evidence supports it. If primary care is more available and better utilized, then Hawai'i's per capita hospital spending should be comparatively low and a larger share off personal health spending should be apportioned to physicians. In fact, that is the case. In 1988, while Massachusetts spent $959 per capita on hospital care and the U.S. average was $688, Hawai'i's figure was $506. Hawai'i, with better overall health outcomes, spent 27 percent less than America's average per capita hospital costs, and 47 percent less than Massachusetts.[8] On the other hand, Hawai'i spends more of its health care dollar on physician services than any other state, with over 30 percent of personal health spending going to physicians. In contrast, the nation averaged 21 percent and Massachusetts about 15 percent for physician services.[9]

Despite the state's emphasis on primary care, significant barriers to primary and preventive services exist in Hawai'i for people covered by Medicare and Medicaid. As elsewhere, both of these federal programs have lower payment levels and present other difficulties for providers, some of whom limit or refuse to accept these patients. Medicaid clients, in particular, tend more often to lack a "medical home," and more frequently use emergency rooms, change physicians, and receive uncoordinated care. While Medicaid is a federal-state partnership, and the state shares responsibility to improve the efficiency and user-friendliness off services, obtaining flexibility to do so from the federal Health Care Financing Administration is cumbersome. Similarly, the less-affluent patients enrolled in Medicare are often disadvantaged in accessing primary care services by Medicare's significantly lower primary-care provider payments, and by high deductibles for such care.

Dramatic Cost Savings

Hawai'i's health care expenditures equalled about 8.1 percent of the gross state product in 1988, or under $1,700 per capita.[10] According to Department of Health estimates, the average per capita figure has probably increased to slightly over $2,000 in 1992. Yet Hawai'i's costs remain approximately one-third less than the nation's. Hawai'i's percentage of Gross Domestic Product for health care is lower than that of the United States, Canada, the Netherlands, Sweden, and Germany.[11]

Hawai'i's cost advantages are related directly to the following factors: Hospital days per capita are less than one-third the national average; hospital beds per capita are one-half the national average; long-term care beds per capita are the lowest in nation; emergency room use per capita is one-third less than the national average (see Table 1).[12]

Some physicians and hospitals allege that Hawai'i's low costs are due primarily to lower provider payment rates imposed by the relatively oligopolistic insurance industry. However, this is not a major factor. Medicare payment levels and physician and nursing salaries, while not the highest in the nation, approximate norms for the western states. Although the 35–40 percent higher cost off living in Hawai'i suggests incomes ought to be higher, the lower purchasing power is the price all state residents pay for living in such pleasant surroundings.

Table 1.—UTILIZATION OF HEALTH SERVICES, 1989

[Per one-thousand population]

	Hawai'i	United States
Emergency room visits	233.0	304.3
Hospital beds	2.5	3.8
Patient days	768	910
Surgical procedures	58	86

Source: Universal HealthCare Almanac (Phoenix: Silver and Cherner, Ltd. 1990).

Further research into the nature of Hawai'i's health expenditures and outcomes would be appropriate and enlightening. Nonetheless, it is already clear that Hawai'i has set a level playing field for the insurance industry and business, by requiring that all workers receive a standard benefit package and by establishing coverage for virtually all residents. While the system is multitiered and has opportunity for further cost-containment, it works; it is real and not hypothetical; it exists in an American marketplace with a minimum off governmental meddling; and, remarkably, it provides generally one high-quality level off care in a mostly fee for-service environment.

IS HAWAI'I A MODEL OR AN EXCEPTION?

It appears from the preceding information that Hawai'i, rather than Canada or some other nation, should serve as a-point of departure, if not a model, for America's health care reform discussions. Hawai'i has achieved nearly universal access to high quality care at costs which, by American standards, are desirable.

Despite these facts, doubts about Hawai'i's relevance and the transportability of its model abound. It is an anachronism to many. The weather is pleasant year-round, and Hawaiians are rumored to live an idyllic lifestyle. The demographics are definitely different, and there is suspicion that Hawaiians are infused with genetic advantages. The economy also is seen as different, and the health care system is suspected to be different. Suffice it to say, something is unsettling for a significant segment of the health policy elite when it comes to Hawai'i's health care statistics. Thus, it is important to examine these concerns in greater depth.

Hawai'i's Economy

The economy off Hawai'i is American. It is home to the usual array of American corporations and businesses. The large to small business ratio is similar to most off the United States, with about 94 percent off Hawai'i's workers employed in firms with less than 50 employees, and 86 percent in businesses off less than 20.[13] The largest industry is tourism, but construction, merchandising, the military, and high-technology industries are each significant. Agriculture is highly visible, but relatively and increasingly less important economically. Manufacturing is not significant. Health care is the third-largest industry!

Unemployment rates recently have been low—less than 3 percent—but they varied considerably during the 18 years of the employer mandate and run higher on the islands other than Oahu (where Honolulu is located). Because Hawai'i has increased trade and investment from Asia and the Pacific, the recent national recession has not been felt as acutely as on the mainland. Bank loans and practices, interest rates and mortgage rates parallel the mainland. Labor unions are well developed and strong in Hawai'i, and recently have become intensely concerned about increasing health costs, particularly in the declining sugar and pineapple industries.

Hawai'i's cost of living is relatively high. The average family in Hawai'i spent nearly half of their income on mortgage or rent in 1991, ranking the state the high-

est in the nation for costs of housing. Nearly every family has more than one person working full time to help pay for housing and the 30–40 percent above national average costs for food, gas, electricity, clothing, and household goods.[14] While multiple earners pushed median family income slightly above the national figure,[15] the average individual's wage was slightly lower.[16] The stress on the family is great and is likely to increase.

Hawai'i's Lifestyle

Many observers believe that Hawai'i's favorable health outcomes and low health-care costs can be attributed to a population that is intrinsically healthier and to the choice of healthier lifestyles. Neither of these assumptions satisfactorily explain the exceptional performance of the state's health-care system.

Hawai'i does have wonderful weather, but so do many other places lacking Hawai'i's good health statistics. Although Hawai'i's climate and "Aloha Spirit" are conducive to regular exercise and relaxation, most residents do not actually get more. While Hawai'i ranks better than many states, it is lower than Utah, Vermont, New Hampshire, Idaho, Minnesota, Wisconsin, and other states in various life-style factors (see Table 2). Hawaiians are increasingly sedentary, eat too much fat and cholesterol, have a propensity to hypertension, drink too much alcohol, have high rates of HIV, hepatitis B, tuberculosis, and diabetes. Even though Hawai'i is better off in life style choices than most states, it is not superlative enough to explain the exceptional outcomes and costs on that basis.

Hawai'i's Unique Demographics

Hawaiians are, on the average, a little younger than other Americans. The median age is 30.9, versus the national average of 31.7; but the state is aging rapidly and will catch up in a few years.

Table 2.—HEALTH RISK BEHAVIORS IN HAWAI'I AND 45 STATES, 1990

(Percentage of population)

Risk behavior	Hawai'i	45 states median	Range
No leisure activity	31.6%	28.7%	18.0–51.9%
Sedentary life style	62.4	58.5	44.5–73.3
Smoking	21.1	22.7	16.8–29.1
Overweight	17.7	22.7	16.3–27.4
Binge alcohol	19.4	15.2	5.5–26.8
Drink and drive	3.9	2.9	0.7–5.9
No seat-belt	4.9	25.9	4.9–59.6

Source: P. Siegel *et al.*, "Behavioral Risk Factor Surveillance, 1986–90" MMR, Vol. 55–4, pp. 1–23.

Everyone is a minority in Hawai'i. Caucasians and Japanese Americans are the largest groups, accounting for about one quarter of the population each (see Table 3). Next most numerous are native Hawaiians and part Hawaiians at about 20 percent. Filipinos, Chinese, Pacific Islanders and many other nationalities are well represented. Many people are of mixed ethnicities, and more than half the marriages are multi-ethnic. This is one of the wonderful features off Hawai'i, but it also leads to many erroneous conclusions about health status. Federal agencies report minority health statistics using extrapolations based on black and Hispanic data; these extrapolations do not work well for Hawaiian minorities, who are mostly Asian and indigenous Pacific peoples.

Table 3.—HAWAI'I POPULATION BY ETHNICITY

Ethnicity	Population	Percentage of total
Caucasian	249,586	23.7%
Japanese	228,567	21.8
Chinese	48,476	4.6
Filipino	126,200	12.0
Hawaiian	9,417	0.8
Mixed Hawaiian	207,146	19.8

Table 3.—HAWAI'I POPULATION BY ETHNICITY—Continued

Ethnicity	Population	Percentage of total
Other	124, 41	11.8
Total	1,048,702	100.0%

Source: Data Book, State of Hawai'i 1991, Department of Planning and Economic Development, State off Hawai'i, Honolulu, 1991.

A common myth about Hawai'i is that its favorable outcomes and low costs can be attributed to the presence off Asian Americans, while the first generation of Chinese and Japanese who came to Hawai'i were a healthy lot, their third and fourth generation descendants are developing the same chronic diseases as other Americans. Japanese and Chinese Americans in Hawai'i, while healthier than Hawaiians, evidence increasing rates off cancer and heart disease due to their American life styles. Recent Department off Health data assessing "years off productive life lost" (YPLLs) due to premature morbidity and mortality suggest that Japanese and Chinese in Hawai'i have more rapidly increasing YPLLs (not a good thing) than Caucasians. Until national health statistics are calculated for minorities other than blacks and Hispanics with greater specificity than at present, groups in Hawai'i may continue to be characterized—as healthier than they actually are.

The population group at greatest risk is the Hawaiian people themselves. Native and part-Hawaiians have health status indices lower than black or Hispanic Americans and than most native American nations. The many Pacific Islanders who have made Hawai'i their home are at similar risk. While the vast majority of native Hawaiians and Pacific Islanders have health insurance, their health problems relate to diet and life style, poverty, cultural barriers to accessing western medicine, and native healing practices. New initiatives planned and implemented by and for these people are being developed to address better their serious problems.

Hawai'i's Medical Care Industry

Hawai'i's health care industry is typical off the nation. Despite talk about prevention and public health, increasing resources go to treating pre-existing diseases with more and more technology and specialization. For a state with less than 1.2 million people, Hawai'i has an impressive array of tertiary care and technology. The university off Hawai'i has well established schools off medicine, nursing, and public health. Hawai'i also has over 3,000 physicians, more per capita than even Israel, and fully 80 percent are specialists.

There is a long-standing commitment to primary care, dating to the sugar and pineapple plantation practice off providing on-site medical care for agricultural workers. This grew into a system of county and then state run rural hospitals and clinics throughout the islands, which provided health care where private facilities and practitioners were not available. The State Department of Health, the oldest in America and second-oldest in the world, still operates 12 hospitals and clinics on each island. The state is moving gradually out of the delivery business, however1 and turning it over—as practicable—to the private sector.

The Prepaid Health Care Act has eliminated the need for typical charity hospitals. All off Hawai'i's hospitals accept both rich and poor patients and, at this point, get paid through insurance, public or private, for nearly all of them. There remains a need, however, for publicly subsidized clinics and community health canters to meet the primary care needs of isolated areas and special populations including the homeless, people with mental illness and/or substance abuse problems, and native Hawaiians.

As previously noted, the Hawaiian insurance market is dominated by two companies. Their domination contributes to lower rates because they have a strengthened position in negotiating rates with providers. The biggest insurer, HMSA, has about 64 percent off the private market. HMSA has an 10 plan, but its main business is a statewide modified fee-for-service plan. HMSA is also the fiscal intermediary for Medicare, and provides most of the Medicaid coverage. Kaiser-Permanente, which came to Hawai'i in 1960, has about 18 percent of the statewide private market. Three smaller HMO and man-aged-care providers have another 7 percent of the market. The remaining 11 percent of the private market is in the hands of commercial insurers. About 82 percent of the population is in the fully "private" market. Medicare accounts for 10 percent and Medicaid for 8 percent of the population, although supplemental private coverage overlaps with Medicare for many of Hawai'i's seniors.

Finally, Hawai'i still has a Certificate of Need (CON) process and a State Health Planning and Development Agency. Many believe that the CON process never sig-

nificantly reduced costs, and physicians and hospitals view CONs as expensive, unnecessary and onerous. Hawai'i nonetheless has an active and dynamic State Health Planning and Development Agency (SHPDA) with an effective community-based planning system, which it intends to keep and include in its health care reforms.

LESSONS FOR IMPLEMENTING NATIONAL REFORMS

The previous section has argued that nothing unique about the Hawaiian economy, people, climate or medical industry explains its favorable cost and health status outcomes; instead, its unique combination of Medicaid, employer mandates and SHIP are probably the dominant factor. But this leads to another policy problem—Hawai'i's financing system is unique because it depends on an ERISA exemption that is probably not replicable. Congress is at present so reluctant to discuss ERISA exemptions that Hawai'i has been unable to obtain permission to make even minor adjustments in its 18-year-old law.

Consequently, national reform is not likely to follow a path of Congress letting states design their own systems. This creates new issues for Hawai'i. Before this year, Hawai'i had anticipated embarking alone on further health care reform primarily through state actions. To do so would have required the federal government to amend the ERISA exemption, and to grant flexibility for better integration of Medicaid services within the overall state system. Hawai'i also was planning stronger cost-containment measures, new incentives for primary care, and a bolder commitment to consumer education and information sharing. State leaders sought to develop1 in essence, a "seamless system of universal access" in which the benefits, claims forms, payment mechanisms, links between private and public insurance, and between health care and public health, are integrated into one network. While government would set the context of guaranteed access, quality standards, and insurance conditions, a private-sector mediated marketplace would establish prices through managed competition, incentives for efficiency and consumer education.

Hawai'i's reform strategy is changing in the face of recent indications of imminent national action. A new national program, which will likely represent a wonderful improvement for most states, may ironically be a serious set-back for Hawai'i. A national single-payor system like that of Canada, a system based on a "play or pay" employer mandate, or a system based on an "individual insurance mandate" as suggested by the Administration or the Heritage Foundation, would undermine some of Hawai'i's accomplishments.

Ironically, the model for Hawai'i's employer mandate came from President Richard Nixon's similar proposal to Congress in 1974. Proponents of the law in the Hawai'i Legislature argued that the State should pass its own version of the mandate before Nixon's slightly different proposal became national law, but 18 years later Congress still has not acted. Of course, health insurance costs were much lower then, and passage of a similar law today would face stiffer opposition than proponents faced in 1974.

When Hawai'i passed its law, the concerns of influential stakeholders had to be carefully addressed. The health industry and consumer groups were included from the beginning to provide input into specifics of the law and into design of the required benefit package. The State supplementation Fund, intended to subsidize the premium costs for hard-hit small businesses, was added to allay small business opposition, even though subsequent use of the fund has been rare.

Small businesses are still concerned about increasing rates; the need for cost-containment remains their top priority. One of the biggest remaining gripes of small and large businesses is the tendency of the Legislature to mandate new benefits for insurers, which translates to increased premiums. Recently, mental health, substance abuse, and in-vitro fertilization benefits have been mandated by the Legislature, in addition to the required benefits of the Prepaid Health Care Act. (This involved changing state insurance statutes rather than the Prepaid Health Care Act, which cannot be modified under the ERISA exemption.) Small businesses also see the need to amend the Prepaid Health Care Act to adjust the cost-share of employees, since employers now pay as much as 80 percent of premium costs for their lowest income workers. The employee's share is progressive, however, and employees earning over $50,000 annually pay half of the premium costs. Some small businesses also want to make the voluntary community rating system used by insurers part of the law; they fear that, unless this practice is made mandatory, insurers will revert to experience rating as health care costs increase. Other small businesses are fearful of any government action whatsoever.

Major concessions also were made to the unions and to big business in the original design of the program. One was that the law had to apply to all workers, ex-

empting no businesses, no matter how small. This proved to be valuable in creating the environment needed for community rating and for minimizing cost-shifting.

The major concern of the private sector reflected in the Pre-paid Health Care Act was that government have no rate-setting or overt control over health care expenditures. This decision has created a competitive marketplace in which payment rates for physicians, hospitals, and medical and pharmaceutical providers and suppliers are not government regulated. As the competition among insurers to community rate eliminated most of the commercial insurers who insisted on underwriting, the two dominant insurers have been able to drive hard bargains with physicians and hospitals. Along with the presence of an active Certificate of Need process for new facilities and equipment, the dominance of two major insurers has enabled aggressive utilization-review and prior-approval processes to keep costs in line.

These conditions may sound austere to providers elsewhere, but they are not so bad. Both major insurers include physicians in practice in their management and advisory boards; several smaller but viable health insurers in the marketplace also play a role in offering providers choices and leverage against the big insurers. The competition is healthy; the controls are generally reasonable; government does not need to be involved; and, despite the concerns that the leading insurers are too powerful, there is a balanced and fair means of establishing payment levels in our state. However, the vital dimension lacking and needed to add further cost-containment to this marketplace is to require sharing of health care industry costs and outcomes information with consumers, businesses, and labor unions. Access to this so-called "proprietary information", to allow consumers to make more informed choices of insurance packages and providers of care, is a necessary future step.

Although one-third of the medical care in Hawai'i is provided in managed care or HMO settings, the other two-thirds is traditional fee-for-service. Physicians and hospitals function pretty much in the same relationships to insurers and each other as elsewhere in the nation. Because fee-for-service medicine has many weaknesses which contribute to cost increases, the State seeks to encourage more managed care options. Implementing more managed and coordinated care requires, however, the development of trust by physicians that the doctor-patient relationship and quality of care will not be sacrificed in the process.

Establishing the SHIP in 1989 again required addressing the concerns of major stakeholders before attempting to proceed. With the committed support of Governor John Waihee, the Department of Health proposed the general concept to the Hawai'i Legislature with a required one year developmental process involving providers, insurers, consumers, business, labor, and government. Benefits, financing, eligibility, delivery systems, and coordination with Medicaid and the Prepaid Health Care Act were analyzed by a vigorous advisory group, with the help of actuaries and health policy consultants.

The result was a program which, when finally approved by the Legislature, had a broad consensus of support and understanding by major stakeholders. The idea finally was accepted by the Legislature because the promoters projected that costs to the state for subsidizing an insurance program for the target population would be cheaper and better than continuing to try to meet their basic health needs through fragmented state services and public clinics.

Hawai'i's island culture, and alleged greater affinity for the notion that health care constitutes a merit-good rather than a private-good, may have played a non-transportable role in establishing both the Prepaid Health Care Act and SHIP. But before the nation and other states dismiss a similar process as unachievable, Hawai'i reminds observers that the consensus needed to create and implement our unique laws was by no means easily achieved. Strong committed leadership must create sufficient momentum to overcome the suspicions and biases of powerful self-interests among insurers and providers. Likewise, leadership must overcome the legitimate fears of small businesses and consumers of adverse selection. The lack of the national leadership necessary to move through this often painful process is perhaps the greatest obstacle to meaningful health care reform.

The Hawai'i political process yielded the Prepaid Health Care Act after a critical mass of constituents, responding to the challenge of key leaders, embraced the concept of universal access—the belief that basic health care is a right or a merit-good. Two factors which allowed this consensus to develop in 1974 in Hawai'i have relevance to the national politics of health care reform today. First, it was—and still is—important to many citizens that government not have a big role in running any mandatory health program. The recent federal policies regarding abortion and the "gag rule" for health providers working in federally-funded clinics underscore the contemporary nature of this concern. Second, the belief in an approach to cost-containment which emphasizes consumer-choice was—and still is—very important.

Hawai'i's employer mandate law addressed these concerns. In contrast, a tax-supported "single-payor" approach tilts power to the collector of those taxes; it would lead to central policy development and to the bureaucratic financial controls and regulations typical of many government programs. Although some health policy "gurus" argue that such centralization is essential to administrative cost reductions and efficiency, Hawaiians felt strongly that it would lead to higher costs, unhappy consumers and providers, less innovation, and perhaps to mediocrity in quality of care. Proponents of "single-payor" solutions also argue that an employer mandate takes money away from low income employees' wages, effectively financing care in a regressive manner. This is a valid concern, but is not the necessary outcome of an employer mandate. In Hawai'i, the employees' premium costs are progressive: the employees pay a greater percentage of the cost as their income increases.

Forcing all employers to provide health insurance to their employees no doubt did cause the price of a hamburger and the cost of dry-cleaning a shirt, for example, to go up a few cents in Hawai'i, but taxes collected for the same health benefits would have increased as much or more for the same employers and employees if government administered the program. The hamburger's price increase could easily be more if a federal tax financed the short-order cook's health insurance. Moreover, getting those tax dollars back from the government in a desirable and efficient manner can be quite difficult. The basic point is that Hawai'i's private insurance system is more popular with consumers and providers than are federal programs.

To succeed, an employer-mandate must avoid the pitfalls of costshifting, provider-greed, administrative inefficiency, and lack of the social conscience to cover the unemployed in some parallel way. Any serious national reform strategy, seeking to take advantage of Hawai'i's experience, should be accompanied by insurance reform, including the elimination of underwriting through community rating; by a required comprehensive standard benefits package; and by the requirement that dependents of the employed be covered. Further, recognizing the goal must include both universal access and cost containment, a successful employer-mandate will require a parallel program to guarantee coverage to whatever "gap" group remains of unemployed, part-time employed, and self-employed people.

Regardless of which approach to national health care reform is selected, other choices of a serious and confounding nature must be made. There are limits to what the nation can afford; careful and deliberate decisions should be reached regarding what benefits will be offered to whom.

Dr. Everett Koop, former Surgeon General, and Robert Laszewski, an insurance executive, recently stated this problem succinctly: "Americans have three basic expectations for health care: immediate access, limited costs, and high-tech medicine. It has not been too difficult to deliver any two of these, but it may be impossible to have all three unless we understand the limits of medicine."[17]

The "limits of medicine" term points to the need to educate consumers that the medical care they demand, usually without knowing how much it costs or who is paying, cannot be viewed as an entitlement, instantly available to cure the ills of an aberrant life style. Similarly, health care providers require help to understand the need for realistic and humane application of the powerful and expensive technologies sometimes wielded in response to the naive and unchecked expectations of their patients. In brief, consumer and provider education are critical to implementing an acceptable program.

Rather than approach education about the limits of medicine as an "exclusive" discussion about rationing, Hawai'i has viewed this topic as "inclusive." Officials ask what benefits, standards and conditions constitute the health care rights of all citizens. Of course, with rights come responsibilities; government's responsibility must be balanced with personal and family responsibility for health, and with business' responsibility for employees. But, some benefits were not included in our programs, and those limits are worthy of examination as the nation considers various reform strategies.

Both the Prepaid Health Care Act and SHIP exclude benefits for dental care, mental health, substance abuse services, and pharmaceutical coverage. AIDS-related care has been evolving as part of the system, but community and home care services for these patients, once they are unemployed, has been funded mostly from other sources. Long-term care services also are excluded; and this is the biggest future cost concern for Hawai'i and the nation. Any serious attempt to address effectively health-care cost inflation will need to consider each of these.

Mental health and substance abuse cost billions nationally in preventable morbidity and mortality, and more in related social and judicial costs. While the chronic aspects of mental illness and substance abuse require behavioral and community-based care rather than traditional medical care, the need for accurate diagnosis and treatment of acute aspects of these problems does require excellent medical and psy-

chiatric services. Hawai'i has developed both a primary care and acute hospital care system for mental illness and substance abuse care, which is included in standard health insurance benefits for all employed persons and in Medicaid. There is a strong utilization review process to prevent inappropriate utilization. Chronic problems are treated by the state-supported "safety net" only after clients have been determined to have received appropriate benefit from acute care services. In this approach, the factor determining what constitutes a necessary benefit for health insurance coverage relates to the acuity of the condition, not the income level of the patient. A chronic schizophrenic, for example, does not typically benefit in the long term from prolonged psychotherapy and acute psychiatric care. Although medical services will be needed to adjust medications or deal with crises from time to time, most appropriate care for these individuals will be community-based case-management and related psycho-social rehabilitation services. These chronic care services for poor and rich clients will be funded from state resources, but not from employer-based insurance.

With respect to dental care, approximately 85 percent of Hawai'i's population has non-mandated dental insurance through employers; in contrast, less than 50 percent of all Americans have such coverage. Prepaid Health Care and SHIP do not cover dental care, but they should. children's dental care and preventive dentistry for adults logically would be covered in any cost-effective program. Not to cover prevention, particularly for children, will cost more in the long run. The limits of coverage should be based on differentiating preventive services from chronic, corrective and reconstructive services.

Long-term care is the single-most costly and most difficult aspect of setting the limits of medicine. As the population ages and the "baby boomers" approach retirement, the costs of long term care will become out of reach not only for individuals and families, but also for government. Long-term care is entwined with Medicare, retirement health insurance packages, and, for the less affluent elderly, with Medicaid. The long-term care portion of Medicaid is the program's most inflationary element and will soon outstrip in cost services to indigent women and children. However, many long-term care services are not health-care services, but are community services needed to maintain independence and support activities of daily living. This subject is too complicated to discuss adequately here; suffice it to say that access to and costs of long term care service must be either included in a national health-care reform, or addressed through a parallel government-sponsored financing system.

Hawai'i is seriously considering a mandatory universal state-sponsored long-term insurance program with necessary cost-containment and utilization controls. Because of the links to Medicare and Medicaid, this requires a partnership with the federal government; the lengthy deliberations have already begun. With the costs of institutional long-term care approaching $45,000 annually in many states and projected at over $100,000 by the year 2000, no one can afford to wait long on this issue. Efforts should be focused on preventing institutionalization through a well-orchestrated system of home and community based care for those at risk.

Finally, in response to the limits to medicine and the necessary limits to resources, citizens must learn to be healthier by choice, by incentive, by design. The HCFA estimates that nationally health care expenditures in 1992 will be nearly $3,000 per capita, of which about 42 percent will be federal spending on Medicare and Medicaid. Yet, the main vehicle for prevention and health education funding to states, the Prevention Block Grant, is funded at less than 60 cents per capita! Prevention and education are not genuine priorities. More funding, perhaps an earmarked percentage of federal expenditures, should be allocated to such initiatives.

The perceived and real limits to achieving universal access to care at affordable costs will vary depending on the philosophical and strategic policy choices made in the critical months and years ahead. A new system of guaranteed benefits can be determined on the basis of what is excluded in terms of high-tech care, or what is included in terms of primary care and prevention. Hawai'i has learned that overt rationing is unnecessary, due to a reduced per capita need for of the most expensive services, significantly based on early decisions made in designing the system.

In view of the reality of limits of resources, limits of medicine, and limits of imagination and experience about what is possible, it is advisable that the designers and implementors of impending health care reforms consider a few key issues, which otherwise are likely to be under-emphasized. The first is the need for an awareness of the parallel importance of strengthening public health, health education and promotion, and prevention for both consumers' and providers' benefit. Second is the importance of building whatever system is selected on a strong and definite foundation of primary care services, incentives, and networks. And, finally, is the opportunity to build on what already works best, and in the Spirit of the new federalism, de-

velop an affordable universal system which is not administered and dominated by the federal government.

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PREPARED STATEMENT OF ALICIA PELRINE

STATE-BASED HEALTH REFORM INITIATIVES—A STATE/FEDERAL PARTNERSHIP

Good morning, Mr. Chairman, members of the subcommittee. I am Alicia Pelrine, group director for human resources for the National Governors' Association. I appreciate the opportunity to talk with you today, on behalf of the nation's Governors, about state-based health reform initiatives and the need for a state and federal partnership as states attempt to implement comprehensive health care reform.

No one questions anymore that America is facing a health care crisis and needs a system that makes health care affordable and available to all Americans. A comprehensive national solution must be found, and the Governors believe that they must play a central role, now and in the future, in resolving the crisis. They also believe, however, that in the absence of the timely enactment of a comprehensive national solution, states must be given the opportunity to work cooperatively with the federal government and the private sector to find their own solutions to the health care crisis. These state initiatives must not substitute for national reform; however, if there is no national consensus, the conclusions drawn from state initiatives will help develop one.

States have a critical interest in finding solutions to our health care crisis. States are major funders of health care for the poor and unemployed. They are among the largest employers within their states, and they must confront this health care dilemma with shrinking economies and balanced budget requirements. Because of these financial pressures, states cannot wait for a national solution. Several have already made significant advances toward comprehensive and available health care.

However, states cannot effect change alone. Effective health reform, even incremental state-based change, requires a relationship among states, the federal government and the private sector—a relationship that moves beyond affirmations of co-

operation to strategies for change. Each member of the partnership must be willing to re-assess perspectives and take risks toward achieving lasting reform.

How can state-based health reform contribute to national solutions?

The expression is worn but still true that states are the "laboratories of democracy." States have a history of generating effective solutions through experimentation. In the last several years, states have taken the public policy and political risks necessary to try new health care strategies. Most notably, they have led the way in strategies to address infant mortality—strategies that have contributed to a reduction in the infant mortality rate across the nation.

There are those who believe that state-based reform initiatives will delay or ultimately defeat the chances of national health reform. The Governors believe the opposite. State experimentation will lead to more meaningful and enduring national health policy. Most states, like the nation as a whole, have urban and rural regions, unevenly distributed socioeconomic conditions, as well as geographic diversity, which makes them perfect laboratories to test the efficacy of different approaches to reform.

But states cannot implement reform alone. Our current health care system has evolved into a complex labyrinth of payors and providers of health care. The system is supported and regulated through an equally complex maze of state and federal statutes and regulations. Meaningful health reform, even at the state level, can occur only when this Gordian Knot is broken. States are capable and willing to change their statutes and regulations. However, to successfully implement state-based health reform, they need changes in federal statutes and regulations that will allow certain strategies to be tested. Moreover, they also need a process by which reform initiatives can be reviewed, approved, and evaluated.

What state and regulatory changes do states need?

(1) The existing waiver process under the Social Security Act must to be streamlined. The existing waiver authority for experimentation is so burdened by administrative complexity that it effectively eliminates the possibility for change. What could be done?

- The Health Care Financing Agency (HCFA) could greatly simplify the application process. The level of documentary evidence required to support waivers has become onerous.
- Waiver authority should be restructured so that waiver requests are deemed approved unless HCFA demonstrated, in a reasonable time frame, that the state failed to meet redefined criteria.
- HCFA could greatly simplify renewal and integration of waiver projects by providing that a waiver would become a regular part of the Medicaid state plan after receiving only one renewal.

(2) Waiver authority under the Social Security Act must be expanded to permit greater experimentation with Medicaid and Medicare. The current Medicaid and Medicare system does not allow states sufficient flexibility for experimentation. States should be permitted to test different delivery systems to provide Medicaid services to Medicaid clients.

- Medicare statutes could be amended so that the existing authority states have to test different reimbursement plans that include Medicare reimbursement could do so for five rather than the current three years.
- Section 1115(a) of the Social Security Act could be amended so that states could test demonstrations for five years without annual renewal.
- Establish authority under Medicaid that as part of a comprehensive state-based reform initiative, states could receive federal financial participation for individuals who would not otherwise have qualified for coverage under the program.
- Once a particular approach to the more efficient use of Medicaid resources has been tested in several states, it could automatically become an option for all other states without requiring them to submit waiver applications.

(3) Waiver authority is needed under federal programs that currently have no such authority—the Employee Retirement Income Security Act (ERISA), tax code, anti-trust statutes. Several important access and cost containment strategies cannot be implemented as a part of state experiments without federal statutory changes.

ERISA. Except for specific statutory exemptions for certain aspects of Hawaii's health care program, no vehicle exists for states to receive an exemption or waiver of the ERISA pre-emption for self-insured plans. States are interested in testing new strategies that would include:

- levying assessments to create statewide pooling arrangements;
- requiring employers to either offer a standard benefits package as defined by the state or pay into a public program;
- developing common administrative procedures that might include uniform claims forms and billing procedures; and
- establishing uniform provider reimbursement rates.

While Governors would like more flexibility under ERISA, they do not want to impose additional insurance mandates on businesses. In fact, most states are developing small, standard packages that would appeal to small businesses. These packages would constitute the minimum requirement for all businesses that choose to pay rather than play in a "pay-or-play" strategy.

The tax code. Some states are planning to establish tax-deferred savings accounts for families and individuals to pay for health care. Establishing these accounts would require changes to the tax code;

Anti-trust. States that are considering the development of a statewide, negotiated, rate-setting system would need protection for themselves and their providers from anti-trust legislation. Similarly, protection from anti-trust legislation is necessary to develop a single claim form for use by all insurers in the state.

How can the federal government facilitate and oversee state reform initiative?

Even if Congress and the administration make all of the statutory and regulatory modifications to existing waiver authority that the states would like, and even if they establish waiver authority in statutes where none currently exists, implementing state-based reform initiatives still would be next to impossible. The federal government must establish a process to facilitate development and implementation of state initiatives. That process must have three characteristics.

- There must be a person or an entity with the authority to grant all waivers necessary to move forward with a health care reform plan;
- there must be a timely approval process; and
- it must be possible for states to receive advice and conditional approval of initiatives as they are developed at the state level.

What is the states' commitment to this partnership?

What do states bring to the table as part of the partnership? At a minimum, states would be expected to ensure that a viable reform initiative is proposed for consideration by federal authorities. All initiatives for state health reform would be enacted by the state's legislature and signed by the Governor. This would ensure that all relevant stakeholders have participated in the proposal's design. Moreover, states will ensure that Medicare services will continue to be provided to the Medicare population, irrespective of the initiative and federally mandated Medicaid services provided to federally mandated Medicaid recipients. Finally, the Governors are committed to a fair and impartial evaluation of their initiatives. Only with such public and impartial scrutiny can these initiatives be seen as models for national reform.

What about financing?

The Governors believe that a viable financing strategy is an essential component of any initiative. Both the federal and state governments as well as the private sector have a strong interest in controlling costs in the health care system. However, expanding access to care will cost money, and the annual cost-neutrality precepts developed for waivers under the Social Security Act must be reconsidered in light of the breadth and scope of proposals that would be considered under this partnership model. States will propose broad-based restructuring of health care systems. To do so they expand access control costs. Therefore, the following principles should guide concerns about the costs of reform initiatives:

- The federal and state governments must be willing to share both the financial risk and the ultimate cost savings.
- Reform initiatives should not be expected to be budget-neutral on an annual basis. Although cost-neutrality of health initiatives would be ideal for both states and the federal government, it should not be the sole determining factor in the approval of state waiver requests. However, initiatives can be expected to be cost-effective and efficient over the life of the project.
- The states will assume responsibility for their share of the increased costs of expanded access. The federal government should do the same. In addition, the federal government should provide some resources to help states develop their initiatives.

- The states will work with the federal government to develop a "stop-loss" proposal to limit federal liability for potential project cost overruns.

By virtue of their presence, state-based health reform initiatives are an important component of the debate for national health reform and will contribute to national solutions. This has been recognized by Sen. Mitchell's HealthAmerica plan and the President's health reform proposal, both will permit limited state experimentation. In direct support of state initiatives, Sen. Leahy and Sen. Pryor are developing a bill that also permits limited state experimentation. We are very encouraged by their work and look forward to their final product. They are confronting the most critical issues that must be resolved if state-based initiatives are to succeed.

Mr. Chairman, this morning I have described a framework by which states and the federal government can work together to address one of the most important problems facing our nation today. As you heard in testimony before you today, several Governors have taken the necessary political and public policy risks that leaders must take to effect meaningful change in this nation. More Governors have plans under development and are taking those risks now. They hope that you will join them in this partnership—a partnership that will contribute to changing our nation's health care system.

Thank you again for allowing me to appear before this subcommittee. The Governors and their staffs look forward to working with you as we work to provide affordable health care for all Americans.

RESPONSES OF ALICIA PELRINE TO QUESTIONS SUBMITTED BY SENATOR RIEGLE

Question 1. Would you please discuss what the Governors' see as essential principles to reform the nation's health care system?

Answer. The Governors believe that the nation must have a system that makes health care affordable and available to all Americans. The system must have sufficient controls in place to ensure the cost-effective delivery of care. They also believe that the system should include a continuum of services that begins with education and prevention, including cost-effective community-based interventions that focuses on the early and routine provision of primary care, provides appropriate acute care services, and accommodates rehabilitative and long term institutional care. Entry into the system should occur at the most appropriate level for each individual and the services should effectively and efficiently address his or her needs.

Question 2. What type of activities are planned for the Governors to continue to work on building a consensus on a specific national health care reform plan?

Answer. The Governors plan to consider national health reform strategies at their next meeting in January 1993. It is expected that they will discuss and develop strategies for the implementation of some form of managed competition approach that gives states the flexibility to assure that the needs of their residents will be met.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, I would like to take this opportunity to commend you for holding, and Chairman Bentsen for scheduling, today's hearing on state-based health care reform initiatives. Our states have frequently been the breeding ground for new and innovative ideas, and there is no reason to believe that this will not be the case with regard to health reform.

No one now disputes that our health care system is experiencing a melt-down. The escalating and unprecedented costs, the ever-increasing numbers of uninsured, and the numerous personal tragedies that result from these problems serve as moving and unrebuttable testimony to this fact.

Mr. Chairman, my constituents appreciate that the President and the Congress are now finally acknowledging that we are in the middle of a health care crisis. Understandably, however, they are increasingly frustrated that we are offering little other than talk for solutions. Quite simply, they are tired of us "addressing issues," and are long-past ready for us to start solving problems.

One place we should look for answers to our overwhelming health care problem is at the state level. State Governments, which are obviously closer to the problem than we are, find themselves being forced into responding. More than 15 states are working on massive system-wide restructuring. At least four states have actually passed legislation that begins to implement massive overhauls of their health care systems.

Unlike the Federal Government, these states have sought and, to the extent possible, achieved consensus within their own borders. These achievements were not

accomplished without controversy. They were also not achieved without political risk, leadership, and courage. Most importantly, though, they were achieved.

This morning we will hear and learn from a number of representatives from states at the forefront of the health care reform movement. We will hear that different states have different health care approaches and priorities. We will learn that, whatever we do at the Federal level, we must leave room and flexibility to the states to respond to the unique needs and desires of their own populations.

Mr. Chairman, as the Chairman of this Subcommittee, you have been particularly sensitive to the needs and potential of states. Over the years, you have built a close and productive working relationship with the Governors and their representatives. Your support, along with that of the Majority Leader, Senator Rockefeller and Senator Kennedy, of the state opt-out provision in "HealthAmerica," illustrates your commitment in this area.

One other great friend and ally to the states is my good friend and colleague, Senator Patrick Leahy. He has long recognized that states have, and will continue to have, a vital role to play in the restructuring of our ailing health care system. This understanding was well illustrated with his introduction of S. 1972, "State Care."

Earlier this year, Senator Leahy and I decided to team up and work together on a bill that builds on S. 1972's important foundation. Like S. 1972, our bill is aimed at cutting through Federal bureaucracy and red tape, and assisting states develop their own unique approaches to comprehensive health care reform for their citizens.

Our bill will be designed to provide narrowly crafted, but important and necessary waivers from Medicare, Medicaid, and the Employment Retirement Income and Security Act. These waivers should provide important and needed flexibility to states which are committed to overhauling their health care delivery systems. We hope and expect to introduce the bill this summer.

Speaking for myself, and I know for you Mr. Chairman, I have not given up on a nation-wide, comprehensive health care reform solution. I believe we must do everything possible to develop a comprehensive reform package that provides relief and assistance for every American. However, as we attempt to meet this challenge, I am convinced we must preserve and protect a state and local role in order to assure the best possible and most responsive health care system for our citizens.

Mr. Chairman, I have long felt that we, as representatives of the Federal Government, are all too frequently negative and overly paternalistic to state-born reform initiatives on almost any issue. Sometimes it seems that if the idea isn't ours, we always find a way to show that it somehow isn't good enough. Well, when it comes to health care reform, at least to date, we have not come up with anything better than what many of the states are offering. To the contrary, we are still talking about reform; they are actually doing it.

Today, Senator Leahy, our dear friend and former colleague Lawton Chiles, Governor Waihee, the National Governors' Association, and representatives from Massachusetts, Minnesota, Oregon and Washington will tell us about where the health care reform action has already taken place—the states. I hope we all will take this opportunity to learn from the leadership showed by these and other states.

I look forward to continuing my close and productive working relationship with Senator Leahy, the National Governors' Association, Governor Chiles, Chairman Bentsen, and many others in our efforts to secure and enhance an important place for the states at the health care reform table. It is my belief that we ignore and roadblock the states' reform efforts at our own, and more importantly our constituent's, peril.

Mr. Chairman, thank you again for holding this important hearing. You have assembled an impressive array of witnesses, and I look forward to their testimony.

PREPARED STATEMENT OF LYNN READ

INTRODUCTION

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to discuss Oregon's health plan with you today. It is our comprehensive proposal for addressing critical issues relating to health in Oregon. Often people have not understood the various components of our plan.

The Oregon Health Plan addresses the problems of 450,000 Oregonians (about 18% of our population) who are without health care coverage and another 230,000 who are underinsured. The plan is based on a set of three laws which guarantee health care coverage for the uninsured. It clearly outlines the responsibilities of government, employers, employees and insurers in addressing the needs of the uninsured.

Many refer to our proposal as a "rationing" plan. We consider it to be a rational plan to address the health care crisis as it exists today. The Oregon Health Plan is one state's response to the challenge of developing an equitable health care resource allocation policy in an era of limits. The plan is not, in and of itself, a final solution but rather a political strategy which creates a process to reach consensus on the policy objective and principles of reform and a framework in which such reform can take place.

BACKGROUND

You are well aware that the percentage of dollars going to health care has steadily increased. Although we spend more than any other country in the world, our health outcomes don't reflect that standing. Despite the amount of money spent on health care, there are millions of Americans who have no health coverage.

There are dozens of health care proposals today to address these health care realities, but most proposals have the same fundamental flaw: they start with a completed plan and then try to sell it. The problem itself and the objectives and principles of reform have never been clearly defined and agreed upon by the general public or by the diverse political stakeholders who influence the legislative process. When such plans move from generalities to specifics, the legislative process is paralyzed by those representing the short-term economic interests of consumers, payers, providers and insurers.

You recognize that reform is not easily achieved. The foundation for meaningful and lasting reform must begin with a consensus on the objective of that reform and the underlying principles that should guide the incremental steps necessary to achieve it. Without such a consensus, reform efforts are fragmented into the kind of patchwork, shortsighted system we are trying to fix.

The challenge is to bring diverse interest groups together around a common objective which forces participants to be accountable for the long-term solution.

Any successful effort to address reform must address two issues: a recognition of fiscal limits and the need for clear accountability in health care resource allocation decisions. There is a limit to the level of taxation the public will tolerate and thus there is ultimately a finite budget from which to fund all the activities of government. State governments are not allowed to operate with deficits and, thus, must balance their budgets. Health care for the poor is a governmental responsibility, but not the only one. As health care costs increase, states must either raise taxes or cut other programs, such as education, housing and corrections, services which may have a direct impact on health. If we accept the fact that the health care budget is ultimately finite, then an explicit decision to fund certain services means an implicit decision has also been made not to fund other services.

In Oregon, issues related to health resource allocation and fiscal limits were introduced to the general public and special interest groups in the mid-1980s. A grass roots organization, Oregon Health Decisions, was founded to bring these issues out into the public domain, to educate, to determine values important to the community, and to build consensus in town after town through a town-hall meeting forum. The debate expanded in 1987 when the state discontinued funding for most transplants in order to allocate funds to services which would provide a greater benefit to a larger number of people. A Governor's Commission on Health Care was established in 1988 to recommend ways to improve access to health care. A trial attempt to develop a process for setting health care priorities was completed in early 1989. This was the foundation on which the 1989 legislature began its deliberation on health care reform.

OREGON'S SUCCESS IN ADDRESSING HEALTH CARE REALITIES

Oregon's success in addressing the health care realities of today is due to two factors. First, we separated the health care debate into four fundamental questions and used this matrix to frame our decision-making process. Who is covered? What is covered? How is it financed? How is it delivered?

Second, we developed a common policy objective and reached consensus on a set of principles which have guided our reform efforts. Our policy objective is to keep all citizens healthy, not just to guarantee all citizens access to health care. Our's is a health policy, not simply a health care policy. It is an integrated approach where resource allocations for health care are balanced with allocations in related areas which affect health. To ensure that political stakeholders, representing vested and often conflicting interests, remained focused on the broad policy objective, we did not start with a completed plan but rather with a consensus on the following principles which would guide our reform effort:

- All citizens should have universal access to a basic level of care.

- There must be a public process to determine what constitutes a basic level of care.
- This process must be based on criteria that are publicly debated, reflect a consensus of social values, and consider the good of society as a whole.
- Eligibility for a public subsidy must be based on financial need.
- There must be a mechanism to establish clear accountability both for resource allocation decisions and for their consequences.

The Oregon Health Plan was not "sold" to the interest groups, but instead emerged from them as decision-making occurred within a framework based on agreed upon objectives and principles.

OREGON HEALTH PLAN COMPONENTS

The Oregon Health Plan consists of three major components passed as law in 1989 and enhanced in 1991, not dissimilar to many proposals before the U.S. Congress. First, there is a high risk pool for persons who are denied coverage due to preexisting conditions.

Second, there is a mandate that requires employers to provide coverage, or pay a payroll tax to provide coverage, for employees and their dependents. Currently this is a voluntary program (with declining tax credits) for small employers. Assuming a target enrollment on a voluntary basis is not reached, work-based coverage becomes a mandate on all employers in 1995. However, the mandate on employers is tied by statute to implementation of the expanded Medicaid program. To help make insurance more accessible and affordable, small group insurance market reforms were enacted in 1991: guaranteed issue and renewal, limits on preexisting condition exclusions, modified community rating and limitations on rate increases.

Third is Medicaid reform and expansion slated to begin in December if federal approval of waivers is forthcoming this month. The elements of the Medicaid plan are quite simple:

- Cover everyone under 100% of the federal poverty level, no matter what their age, sex or family status.
- Guarantee them a benefit package which will focus on those services having the greatest impact on their health.
- Deliver those benefits through managed care, a system which will assure access, quality care and cost containment.
- Pay for those services at reasonable rates, reducing or eliminating the cost-shift and increasing provider participation.

The various components of the Oregon Health Plan embrace cost containment with a benefit package, based on priorities, which promotes health through prevention, early intervention and primary care; reliance on managed care delivery systems; formation of a health resources commission to control use and distribution of costly medical facilities, technologies and services based on health outcomes; and development of practice guidelines by the Oregon Medical Association to reduce the incidence of inappropriate care due to the wide variation in the way physicians practice medicine.

STANDARD BENEFIT PACKAGE

Virtually every congressional health reform proposal calls for the provision of "basic health care benefits" without specifically identifying covered benefits or defining a process to determine what constitutes a "basic health care benefit." In Oregon, we have designed a process for determining our benefit package based on the clinical effectiveness of various procedures in treating various conditions, and on community values expressed in dozens of meetings held throughout the state. A health services commission consisting of physicians, other health professionals, and consumers used these factors to rank, in priority order, all health services offered by modern medicine. The work of the Commission and those who participated in its process is an example of citizen involvement at its best. The 25,000 hours of volunteer time invested by Oregonians in the prioritization project has produced a highly credible result.

An independent actuary priced the list and, within the context of competing needs and available resources, the 1991 Legislature determined what constitutes the Standard Benefit Package. The Legislature was prohibited from altering the list; so, starting at the top of the list, the Joint Ways & Means Committee determined how much could be funded from available revenues and what additional revenues would be needed to fund an acceptable basic package. The benefit level is directly linked to fiscal limits.

The old traditional Medicaid options of cutting provider reimbursement to levels below cost or eliminating entire categories of "optional" services or changing eligibility levels were not available to the 1991 Legislature. The state could no longer arbitrarily ration people for reasons of budgetary expediency. Everyone retained coverage; the debate centered on the level of that coverage—what we as a society are willing to fund, and thus guarantee, to our citizens.

Because the Committee had limited resources, it was clear that increases in the health care budget must come at the expense of other programs. This allowed the Legislature to develop an overall **health** policy which recognizes that health can be maintained only if resources in a number of related areas are responsibly balanced.

With the priority list, the tools of implicit social rationing have been statutorily eliminated. Because it is now clear exactly what services would be included by incremental increases in funding and what services would not be included, the Legislature is also clearly and inescapably accountable not only for what is funded in the health care budget, but also for what is not.

As a result, the 1991 Legislature appropriated an additional $33 million to the Medicaid demonstration and funded all services through Line 587 on a list of 709. The resulting benefit package is eminently defensible. It covers virtually all current Medicaid mandates including all preventive, maternity and screening services. It also covers a number of important services not required by Medicaid, such as dental services, hospice care, prescription drugs and most transplants.

The Standard Benefit Package will be available to the Medicaid population this year and a substantially similar package must be offered to all employers in the small group insurance market. It will also serve as the basic benefit package for the work-based employer mandate in 1995. A future legislative session will explore replacing Oregon's current insurance mandates with the Standard Benefit Package.

CONCLUSION

In order to implement this program as a "demonstration," we need waivers of Title XIX of the Social Security Act.

Oregonians don't consider our plan to be a substitute for a definitive national solution. However, the Oregon Health Plan is reasonable, equitable, affordable, and practical. We will learn what works and what doesn't work for Oregon. There will be lessons here for other states and implications for the federal government. Prioritization can be used in combination with other models which must define a basic benefit package, such as a single payer system or other play or pay proposals. Areas where further congressional action is indicated will be identified, such as streamlining the Title XIX waiver process and addressing limitations on states imposed by ERISA, the Employee Retirement Income Security Act of 1974.

Until a national solution is enacted, the Oregon Health Plan represents a significant improvement over the status quo which categorically denies health care coverage to millions' of people simply because they cannot pay for it. It addresses the immediate health needs of Oregonians and honestly and openly tackles the issue of what medical care is necessary to maintain and promote good health.

But perhaps the greatest contribution in developing our plan is the debate it has forced on issues which we as a nation must address if we are to succeed: the courage to be truthful in facing the issues of limits; accountability for the human consequences of our decisions; and the need for a defensible public policy, guided by principle and conviction, not by politics and expediency. We have clearly demonstrated that diverse political stakeholders can be brought together in common cause.

The Oregon Plan is a model of leadership. And it is leadership which will determine whether we as a nation take the problems we have inherited and resolve them in order to ensure our children's future.

RESPONSES OF MS. READ TO QUESTIONS SUBMITTED BY SENATOR RIEGLE

Question No. 1. Most of the state programs discussed on the panel, with the exception of Minnesota, use the current employer-based system to expand private health care coverage. This is also the approach we used in HealthAmerica. Would each of you comment on this particular model and the benefits you see from your state perspectives of this approach? Also, how important is it to have a strong cost containment program? If a strong cost containment program were to be put in place, wouldn't this help employers and make the requirement on employers less financially burdensome?

Answer. Expansion of private health care coverage using the current employer-based system has several benefits. First, both the strengths and weaknesses of the current system are known and can be addressed in design of the expanded coverage

system. Second, health care financing built on a public-private partnership is consistent with the American form of government. And last, to effect meaningful and lasting reform, a diverse group of political stakeholders must reach consensus on the objective of reform and the underlying principles that should guide the incremental steps necessary to achieve reform. We are more likely to reach such a consensus if we build from our current system of health care financing.

A strong cost containment program is an essential component of reforming our health care system. Our resources are limited and our health care demands are potentially limitless. We need to ensure the health care system to which we expand access can be sustained in future years. A health care system with strong cost containment measures will certainly be more affordable for employers than one without such controls.

Question No. 2. You have all stated that state-based reforms are not a substitute for a national solution. The roles of the Federal and state governments were strongly considered when we crafted HealthAmerica. We wanted to make sure there was enough flexibility at the state level to account for varying state needs and problems. Setting aside the current Federal barriers to individual state-based reforms, what do you feel the Federal role should be in a national reform program?

Answer. The Federal role should be one of leadership in reaching a consensus on reform efforts that holds decision-makers accountable for the consequences of those decisions. The Federal government needs to take on additional financial responsibility for health care financing in the public program. The Federal government should not cost-shift to state government. The Federal government needs to define a basic benefit package based on effectiveness of treatments which will apply as a minimum standard to both public and employer-based coverage (e.g., any requirement related to EPSDT in the public program would also apply to children in employer-based plans). The Federal government needs to allow states flexibility in their management of the public program (e.g., allow states to mandate beneficiary enrollment in cost effective, quality managed care programs). The Federal government should continue to allow states to experiment, with waivers granted by HCFA, on innovations to health care financing and delivery.

Question No. 3. A common provision in many of the comprehensive proposals, including our bill HealthAmerica, is a National Health Expenditure Board which would set overall spending goals for different health services and for the states. The Board would then convene negotiations between purchasers of health care, like unions and businesses, and providers to establish fair and reasonable payment rates for services and other mechanisms to control costs. We would also establish similar entities at the state level, so states would have the flexibility to determine their own rates as long 85 they stayed within the state budget goals established by the Board. What role should the Federal government have in getting health care costs under control nationwide? How effective do you believe this model would be in reducing health care costs in the states? What is your opinion of implementing this type of process for determining rates where the interested parties are brought together?

Answer. A process for determining rates where the interested parties are brought together is valuable as long as government has the authority to set the rates if negotiations fail. If states are to be bound to a budget "goal" (is this a target or a limit?) set by the Board, then states need to have flexibility to not only address rates but also utilization controls. States should not be bound by federal regulations which require cost inflationary reimbursement for special interest groups such as federally qualified health centers. States also need the flexibility to require participation in managed care plans which are cost effective.

PREPARED STATEMENT OF ROBERT RESTUCCIA

With the passage of Chapter 23, the Universal Health Care Law, in 1988 Massachusetts became the first state in the nation to make basic health care a right of every citizen. The passage of the Law set in motion a four year plan to improve access to health care for the uninsured and the underinsured. Chapter 23 was the product of political compromise. The access provisions of the law were tied to generous hospital reimbursement formulas and a reduction in the business contribution to uncompensated care.

An objective assessment of this Law is difficult to find. The Law does provide very important improvements in access to care for the people of the state. But it is not pancea—it does not resolve all of the problems in the state's health care system. At the same time reports of the Universal Health Care Law's failure have been greatly exaggerated.

Contrary to many accounts, the Universal Health Care Law has not been repealed. Important programs are in place that bring health care coverage to thousands of people. The major access program, "the play or pay" provision which requires all businesses with six or more employees provide health insurance or pay a surcharge into a health care fund, has been delayed until 1995, not repealed. Polling data in the state shows that the Law continues to have strong public support.

The Massachusetts experience with the Universal Health Care Law offers many important lessons for those concerned with health care reform:

LESSON 1: STATE REFORMS CAN HAVE A SIGNIFICANT IMPACT ON ACCESS TO CARE

The Universal Health Care Law's original intent was to expand access through the gradual implementation of a series of programs and initiatives. While some of these initiatives have been repealed or lapsed, many unique innovative programs are in effect including:

- **CommonHealth.** This was the earliest Universal Health Care program. For almost four years this program has been providing medical coverage to disabled adults wanting to return to work, and disabled children. There are currently 2,800 people on the program. In order to qualify for the disability programs one must meet the SSI definition of disability. Premium contributions from recipients are required on a sliding fee basis. For people with disabilities the coverage includes Medicaid level benefits including services that are not part of the usual private insurance benefit package.
- **The Student Mandate.** Beginning in September of 1989 all colleges were required to ensure that all full time students would have basic health coverage.
- **The Hospital Uncompensated Care Pool.** The pool began operating under new regulations in October of 1989 to ensure expanded access to hospital services for low and middle income underinsured and uninsured residents.
- **CenterCare.** Beginning in May of 1989 this program has provided managed care for low income residents through independently licensed community health centers. There are over 7000 patients currently in Centercare.
- **The Health Security Plan.** Begining in July of 1990 this program has provided health benefits to people collecting unemployment insurance. Despite the current Governor's lack of support, there are currently over 32,000 Massachusetts residents covered by the Health Security Plan.

LESSON 2: THE "PLAY OR PAY" APPROACH HAS NOT FAILED IN MASSACHUSETTS. IT HAS NOT YET BEEN TRIED

Since the implementation of this provision has been delayed until 1995, from a policy perspective one cannot make any judgements about this approach from the Massachusetts experience. On the other hand, from a political perspective, the Massachusetts experience shows the difficulty of sustaining a coalition on health care reform until full implementation. The political environment in the state has changed radically since the Law's enactment. Perhaps the most significant change is that we now have a Governor who is hostile to the Law. The coalition that originally supported the Universal Health Care Law is fragmented. This has provided an opportunity for the critics of the Law to delay or repeal it. Whether the "play or pay" provision is implemented in 1995 remains an open question—hinging particularly on who is elected Governor in 1994.

LESSON 3: IMPROVING ACCESS TO CARE MUST BE COMBINED WITH CONTAINING HEALTH CARE COSTS

The major problem with the Universal Health Care Law has nothing to do with its access program. It is that the Law fueled health care inflation by increasing reimbursement to Massachusetts hospitals. The earliest versions of the Universal Health Care Law were not as generous to the hospitals as the final Law. The tremendous political strength of the hospitals changed this. In September of 1987 the Massachusetts Hospital Association brought 10,000 hospital employees to the steps of the State House holding banners that "cost containment has gone far enough."

For most of the 1980's the people of Massachusetts were protected from the high cost of health care by the economic boom. Now, the region is still in a serious recession and the true impact of our health care problems is being felt as costs skyrocket. Massachusetts has one of the highest per capita health care costs in the country. Massachusetts hospital costs are 40% higher than the national average. Without controlling the cost of health care we cannot significantly improve access to health care. We are just putting our finger in the dike of a relentless tide.

The generous hospital reimbursement formula of the Universal Health Care Law has contributed to large increases in health insurance premiums, further straining an already overburdened system. Reducing health care inflation is key to making access programs affordable.

LESSON 4: STATES NEED THE HELP OF THE FEDERAL GOVERNMENT TO TRULY REFORM THE SYSTEM

States are significantly hampered in their efforts to reform the health care system by ERISA, federal tax laws, and Medicare and Medicaid regulations which make it difficult to merge these programs into a universal state system. For example, four years after passage we are unsure whether the Universal Health Care Law will be determined to be a violation of ERISA. While state will always play an important role in health policy, a national solution is the best approach.

LESSON 5: ACTIVE CONSUMER HEALTH MOVEMENT IS A KEY ELEMENT IN WINNING HEALTH CARE REFORM

Consumer participation in the health care debate was key to making access an important part of the political agenda in Massachusetts. In Massachusetts, Health Care For All has taken a leadership position in developing a coalition for broader health care reform that addresses both state and national issues. Given the power and resources of the entrenched interests at both state and national levels, health care consumers will need to be well-informed and well-organized if they are to influence health policy and make the system respond to their needs. Health care reform will come about because the people of this country will demand it as the system fails more and more people.

The full implementation of the Universal Health Care Law will not cure our ailing health care system in Massachusetts. But it is a significant step forward. For the first time the issue of access to health care was placed high on a states' agenda.

The challenge for Health Care For All in Massachusetts will be to fend off opposition to the Law while building a coalition that will support efforts to improve access and contain health care costs. But the long range solution must have a national component. At the same time political support for national efforts will be bolstered by state successes. Health Care For All will continue to fight for improvements in the Universal Health Care Law and a more comprehensive state program of reform while working for national solution.

RESPONSES OF MR. RESTUCCIA TO QUESTIONS SUBMITTED BY SENATOR RIEGLE

Question No. 1(A). What are the benefits of an employer based approach to expanding access?

Answer. The primary benefit of using an employer based approach is that it involves less disruption of current health coverage arrangements than would a transition to a single payer plan. It is worth noting that although the percentage of our population covered by health insurance is declining, it is still much higher than in any country at the time they enacted a single national plan.

There are two main drawbacks to the employer approach. First, there is a risk of developing a two tier system, with those in the public plan receiving fewer and lower quality services than those covered in the private system. (This problem can be addressed by requiring uniform benefits as has been done in Germany). The second problem is that cost containment efforts are more complex and difficult with multiple payers than with only one.

Question No. 1(B). How important is a strong cost containment program? Would such a program make an employer mandate less burdensome?

Answer. Cost containment is a critical element of any universal access plan. It is a missing piece of the Massachusetts program. Without strong cost containment, spending increases will undermine all attempts to expand access. With respect to the employer burden, I believe that this problem is overstated by employers reluctant to contribute their fair share. Currently some employers are enjoying a competitive advantage by not offering health insurance. If all employers participate in a national program, there is no disadvantage to any employer.

Employers will pass most of the cost of an insurance mandate onto either their employees or their customers Ultimately, however the financing system is organized, the cost of our health care is born by the American people. The critical question is how can that cost be most fairly distributed, and how can we maximize the benefit from the dollars we are spending.

When looked at from this perspective, I believe that the answer is that best financing system would be a progressive income tax used to pay for a universal program that provided uniform benefits and paid providers based on uniform fees.

Question No. 2. What should the federal role be in a national reform program?

Answer. I believe that optimally, the role of the federal government should be to collect revenue to finance the health care system, to establish an overall budget for the system, and to establish minimum benefits. It is important that with respect to benefits we not fall into the same trap as Medicaid and allow enormous variation in eligibility or covered services. Assuming that the federal program is employer based, states should have the flexibility to establish single payer systems which means requires flexibility in Medicare and Medicaid (or Americare) payments, and ERISA exemptions provided states are guaranteeing access and containing costs. In addition, the federal government must play a lead role in reorienting our medical education system to increase the number of primary care practitioners, particularly those working in medically underserved areas.

Question No. 3. What should the federal role be in getting health care costs under control nationwide and how effective would a national expenditure board be in containing costs?

Answer. A mechanism similar to national and state expenditure boards as described in HealthAmerica has been an effective device in moderating cost increases in other countries. It is critical that those paying the bills be involved in setting the rates (unlike most current rate setting systems in the U.S.). An expenditure board should control capital as well as operating costs. The advantage of public financing is that it provides additional downward pressure on costs by requiring Congress to actually vote for a tax increase in order to raise "premium" rates.

Reliance on an expenditure board alone will not be sufficient to ensure the delivery of quality cost effective care for all Americans. In addition we must change the financial incentives which currently encourage health providers to perform unnecessary medical procedures and also change our system of medical education and the rewards we give to specialists to encourage more physicians to focus on primary care.

PREPARED STATEMENT OF SENATOR DONALD W. RIEGLE, JR.

Today's hearing will focus on innovative programs states are developing to control health care costs and expand coverage to their uninsured citizens. State experience is an important part of the national debate on health care reform. At the same time, the states cannot alone solve the health care crisis in our nation. This hearing complements hearings Chairman Bentsen is holding to examine proposals to reform our health care system.

Our health care system is in crisis. We spend more than $800 billion on health care annually, or about $2.2 billion a day. A decade ago, a family's out-of-pocket costs were $1700 in 1980 and rose to $4300 in 1991. At the same time, more than 35 million Americans have no health care coverage. Skyrocketing health care costs and the growing number of Americans with no health insurance are signs that our health care system must be reformed.

State officials see the crisis first hand and have direct experience in this area. States are major purchasers of health care, primarily through the Medicaid program, but they also regulate insurance, license health care professionals and institutions, allocate capital resources, and deliver services.

In 1990, state and local government spending accounted for 13% of total national health care spending. Total real spending on Medicaid alone has increased from $27.4 billion in 1975 to almost $65 billion in 1990. Medicaid is accounting for a rising percent of state budgets in the 1990's and is now in the double-digits. At the same time, the percentage of uninsured people varies widely among states from 8 percent to as high as 26 percent in other states. The need to respond to high health care costs and these human needs coupled with limited state budgets are a force for reform in States.

Recent developments in many of our states illustrate that reform can be done. So far this year, Florida, Minnesota, and Vermont have passed comprehensive programs and more States are considering proposals. Hawaii has had a comprehensive program in place since 1974. I am very pleased that the Governors, Senators, and representatives of these states are here today to testify about their programs. We also have experts from Washington, Massachusetts and Oregon to testify about activities in their states.

The lessons we learn from state experience will be critical to helping us develop a consensus on national health care reform. In this hearing, we will find out how

states' proposals were developed, the difficulties states face in implementing plans, and how the plans affect access, cost and quality of care.

State and Federal governments clearly need to work together on reforming our nation's health care system, both now and in the future, as Congress moves forward on reaching a consensus on national reform. But more immediately, states face Federal barriers to implementing innovative plans and we want to work with you on this. But I think we all agree that these state initiatives are not a substitute for national reform. Ultimately, the federal government must be involved to ensure that skyrocketing costs are controlled and basic coverage is guaranteed for every American.

PREPARED STATEMENT OF HON. JOHN WAIHEE

Thank you for the opportunity to contribute to national health policy development by outlining Hawaii's innovations and ideas for national health care reform. We appreciate the opportunity and recognition you have given by inviting us here today.

Hawaii is often thought of as a tropical paradise. What isn't known is the fact that we have one of the best basic health systems in the nation. Our system delivers high-quality care for low cost, despite our high cost of living. While we emphasize early intervention and outpatient treatment, Hawaii enjoys high-tech tertiary care programs as advanced as any state or nation. The key to our success, I would hold, is our state's longstanding commitment to ensuring that basic health care is available to all our people -- we have 100% access and 98% coverage. Another cornerstone is Hawaii's innovative health care community which experimented with short hospital stays, outpatient surgery, and preventive health programs some time before they became the norm on the mainland United States.

Our state has a mandated employer benefits program, the only one of its kind in the nation, a Medicaid program which reflects our people's high commitment to those in need, and coverage to those left in the gap between these other programs through our new, subsidized State Health Insurance Program (SHIP). We don't offer these programs as panaceas for the national crisis of the uninsured. But, they are applicable to the national debate on health care, and we are glad to offer our contribution at this forum and together we can contribute to national policy in health care.

HAWAII PREPAID HEALTH CARE ACT

Let's start by exploring a few basics about the Hawaii system. The Prepaid Health Care Act was adopted in 1974 to provide health insurance and medical protection insurance for virtually all employees in the State. The Act is administered by the State's Department of Labor and Industrial Relations. This measure was passed after six years of study and policy development, in a time of moderate unemployment.

The Prepaid Health Care Law is the nation's first and only state mandated benefits plan. Employers are required to provide health insurance to their employees. Dependent coverage is optional. Costs are shared. The employee may pay up to 1.5% of monthly wages, up to half the premium cost. The employer pays the balance. Under the law, employers may provide benefits through self-insurance as long as those basic services are provided. There are coverage alternatives, a fee-for-service plan and a health maintenance plan. The fee-for-service plan -- most used in Hawaii -- provides a good package of diagnostic and treatment services, using co-payments to reduce over utilization. The HMO provides a generous package of benefits.

Any employee who works over 20 hours a week and makes a minimum per month is eligible for Prepaid Health Care. Because the program is administered in conjunction with temporary disability and workers' compensation insurance, no large state bureaucracy was created to administer Prepaid Health Care. A Premium Supplementation Fund assists small employers who cannot, because of economic limitations, provide the insurance, and helps employees whose employers have gone out of business or who have not provided for the insurance. This fund has had minimal use over the 17 years of the program. Administrative and legal sanctions are available for use when employers do not provide the mandated coverage.

Excluded from the provisions of the Act are government employees (who have their own plan), seasonal agricultural workers, real estate and insurance agents working on commission, individual proprietorship members in small family business, and government assistance program recipients.

Effects on Business:

Prepaid Health Care has been very successful in bringing about coverage without negatively affecting business. Effects on unemployment have been negligible. As can be noted (Chart 1) after an unemployment rate averaging about 7% during the 1970s, unemployment has dropped significantly in the 1980s. Thus, while enacted during a period of high unemployment, the measure does not appear to have had a negative effect upon employment--a frequent fear of small business. In fact, over the last 16 years our unemployment rate has fallen to the lowest in the nation (I make no claims about a cause-effect relationship in this regard, but this seems to at least cast some doubt on assertions that such mandates will cause unemployment).

In addition the Act does not appear to have an adverse effect on "start up" of new businesses. As Chart 2 shows, the State has shown a consistent growth in overall businesses since 1970. Looking at a more refined measure, the start-up and termination of unemployment insurance accounts by businesses (Chart 3), it should be noted that there is no discernable downward trend related to Prepaid Health Care. We can thus see no effect on the growth of businesses as a result of Prepaid Health Care. These figures are particularly striking for Hawaii, a small business state. About 97% of our businesses employ less than 100 and 94% have 50 or fewer employees. As you can see, our employer mandate has not had an overall negative effect on small business in Hawaii.

Effects on Access:

The effects of Prepaid Health Care is evident on access. In 1971, a survey showed that those without hospital insurance were almost 12% of our population and those without physician insurance were more than 17% of the population. Implementation of Prepaid Health Care dramatically dropped those figures. Estimates of those enfranchised with health insurance range to more than 46,000. Other people were provided better coverage. The Department of Health estimates that those figures grew with the shrinking of Medicaid during the 1980s to approximately 5% in 1987-1988.

ERISA AND PREPAID HEALTH CARE

The Prepaid Health Care Act was passed just months before the Federal government passed the Employee Retirement Income Security Act (ERISA), which among its detailed provisions preempted state employer mandates. After long court challenges, special Federal legislation was passed in 1983 which allowed the Hawaii mandate to continue. The exemption, however, used as its base the 1974 law. Since that time, Hawaii's health care environment has changed but the state lacks the ability under the exemption to amend the Act to reflect these changes.

While the 1974 Act still serves us well, we would benefit from the ability to change elements of the system which need updating. Such areas as coverage of dependents of workers, cost-share change between employer and employees (especially with respect to higher income employees) and benefits have been mentioned by various interest groups as possibilities for amending the Act.

COMMUNITY RATING FOR HEALTH INSURANCE

Because our Prepaid Health Care program requires that virtually all employers must provide insurance, Hawaii's major health care insurers (HMSA and Kaiser) can maintain health insurance rates for small employers which are comparable to those enjoyed by large employers. This has happened because the two major health insurers in Hawaii (both non-profit) voluntarily use modified community rating for small businesses. By pooling the entire small business market in this way, rates for comparable coverage are kept well below rates for small business elsewhere in the country (see Table 1). Our community rating spreads risk across the entire small business community and does not focus on practices prevalent throughout the rest of the United States which try to find and sell insurance to "low risk" people, leaving the "high risks", or those without the ability to pay high rates, without insurance.

The results have been extremely positive. Small business can purchase insurance at reasonable rates. Employees are covered with health insurance. Insurance companies cut administrative costs and can market to a large pool of businesses. Prepaid Health Care has provided a uniformly level field for competition in which responsible small businesses who provide health insurance are not at a competitive disadvantage relative to those who do not.

MEDICAID

Hawaii's Medicaid Program services over 89,000 persons with a budget of about $360 million in FY 1992. It provides for coverage of persons up to 62.5% of the Federal poverty level. Benefit coverage in our Medicaid program is generous, entailing most of the optional services allowed under Title XIX. The program is administered by the State's Department of Human Services.

Hawaii provides Medicaid to both categorically needy and medically needy people. The elderly and disabled with income up to 100% of the poverty level, and children under age 6 whose family income is up to 133% of the poverty level, are covered. We opted to provide coverage for pregnant women and infants with income up to the maximum allowed by statute (185% of poverty). We also implemented the "presumptive eligibility" provision for pregnant women to encourage early prenatal care. The State also provides a General Assistance Medicaid program for indigent persons who do not otherwise quality for Federal assistance. This program is identical in benefits to the Federally matched program.

We are concerned with recent cost increases in the Medicaid program, similar to those in other states, and are currently developing means whereby we can still provide the needed high-quality services at lower costs.

STATE HEALTH INSURANCE PROGRAM

The State Health Insurance Program (SHIP) was implemented to meet the needs of the small gap group remaining between Prepaid Health Care coverage and Medicaid. This group did not consist of the entire uninsured population, but largely of persons with low incomes and no alternate coverage. This group was estimated to number about 30,000-35,000 persons. There were: 1) Dependents of low-income workers, particularly children; 2) Part-time workers (less than 19 hours); 3) the unemployed; 4) some seasonal workers; and 5) Low-income commissioned sales persons. SHIP provides access to basic health care services to these persons by building upon Hawaii's Prepaid Health Care Act and Medicaid.

SHIP is a partnership between government, individuals and families, and the private sector. Government subsidizes insurance premiums for those unable to pay. Insurance companies provide the coverage and the already existing health care providers deliver direct care. This is essentially the model adopted by the State of Washington in its pilot Basic Health program.

Benefits

Benefits of SHIP are heavily weighted toward preventive and primary care, with health appraisals and related tests, well baby and well child coverage and accident coverage fully covered. Twelve physician visits are allowed with a $5 co-payment during the course of the year. An individual's hospitalization, however, has been limited to 5 days. Two days is allowed for maternity care. Elective surgery, and high-cost tertiary care have been excluded. The program assumes that most members of the gap group will qualify for Medicaid after exercising "spend down" for these costly procedures.

Costs

The insured's share is based on a sliding fee scale where individuals pay a portion of the cost on a monthly basis and are billed directly by the insurance company. This fee scale is based upon ability to pay. Persons below the poverty level pay no fee and the monthly charges for those above poverty increase with income level. Co-payment at the time of a non-prevention visit is $5 and is required for all subscribers.

SHIP Carriers

SHIP insurance is delivered through contracts with the State's two largest insurers -- Hawaii Medical Services Association (HMSA), which has about 60% of all health insurance in Hawaii and Kaiser Permanente, which has about 17%. Both have cooperated enthusiastically with us in this program.

The Hawaii Medical Service Association contract covers the bulk of SHIP's subscribers with a statewide fee-for-service plan, although we do propose HMO coverage be developed. Almost one-half (about 1,200 physicians) have signed on to participate in SHIP through HMSA. Only 20% of SHIP's funds can be used for in-patient hospitalization. The philosophy that we've adopted is that hospitals provide for care for this group already -- much of this is uncompensated. The additional funding, even if it does not cover the whole cost of care, will assist the hospitals in providing for their needs.

The Kaiser contract is limited to 3,500 subscribers on the island of Oahu. Kaiser subsidizes a portion of the costs of the coverage for their full health maintenance coverage for these people.

Program Implementation

SHIP was launched statewide on April 16, 1990. From the beginning, its objective has been to eliminate the barriers and red tape which often deter the genuinely needy from getting government services.

Our major task has been to bring people into SHIP, to target what would be in any state perhaps the most difficult to reach, those people who are outside of the system. We have emphasized the non-traditional, with shorter application forms, instant access for special groups (pregnant women), and special outreach efforts to hard-to-reach groups such as immigrants.

This effort has resulted in coverage for many. As of May 1, 1992, we have an enrollment level of about 13,300 members aboard HMSA-SHIP and 3,500 in Kaiser-SHIP. As expected, SHIP members are, in general, young (43% are under age 18 and 86% under 45). Outreach in rural areas appears to have been successful -- almost 48% of SHIP clientele is from the generally rural neighbor islands. Sixty-five percent (65%) of SHIP membership has family income below the Federal poverty level, with almost 85% of the membership below 150% of the poverty level. Our SHIP population mirrors the population of uninsured found in the Robert Wood Johnson demonstration project and in Washington State's Basic Health Plan. It is young, healthy and a good risk for insurance. Program utilization, given our short experience, appears to be good.

HAWAII'S EXPERIENCE AND NATIONAL HEALTH POLICY

We believe our experience has real relevance to the nation's efforts to bring access to all of its people, at affordable costs. In brief, these are:

#1. Mandated employer coverage can be an effective tool for universal access -- without negative impact on business.

Hawaii's employer mandate brings large numbers of our people under the umbrella of health care coverage. While this approach is sometimes criticized as being "anti-business," it actually is in accord with America's faith in the free enterprise system to find cost-effective solutions to complex problems. Through an employer mandate, government defines the extent of coverage and uses the competitive marketplace to provide that coverage cost effectively and efficiently. By requiring employers to cover their employees, an employer mandate avoids complex governmental bureaucracies and allows business to get the job done well.

Data and experience shows that, contrary to small business fears, our mandate has not brought about a bad business climate in Hawaii. Business growth and employment have not been impacted in negative ways, despite concerns expressed prior to our mandate's passage which mirror the same arguments we find against a national employer mandate. These fears did not, in fact, prove to be substantiated then and we do not believe they are substantiated now. Our employer mandate has leveled the playing field for all employers and has ensured a strong package of health care benefits for all.

#2. We have also learned that insurance reform is vital to the success and equity of an employer mandate. What is also quite clear is that an employer mandate helps to ensure that insurance reforms are successful.

It is only fair that a mandate be accompanied by affordable insurance rates, which are possible in Hawaii through community rating, and the appropriate prohibition of such practices as exclusions and non-renewability. Our community rating is voluntary, a likely product of the important role of our two large non-profit insurance providers in Hawaii's market. This voluntary modified community rating system works to keep our rates the lowest in the nation -- essential in a state with a preponderance of small business that could not afford ratings based on the same factors that govern coverage in most other jurisdictions. The insurers have been able to maintain this system without a specific legislative mandate because all employers must purchase coverage. Because all employers are in the risk pool, community rates are affordable. Because the insurance companies must compete, the market, not governmental control, keeps the rates competitive. Thus, insurance reforms are necessary to the success of an employer mandate but the mandate is also likely to assist in making the insurance reforms viable for insurance companies.

#3. Primary health care works, not only to resolve health needs, but to contain health care costs.

Historically, Hawaii's doctors emphasized outpatient care instead of hospitalization. Today's modern practice patterns reflect this orientation. Our Prepaid Health Care Act makes it possible for most people living in Hawaii to finance this care. Today, our health indicators show the results of primary care. We have low infant mortality and low rates of premature death due to chronic disease such as heart disease and cancer (see Table 2). We use hospitals less (see Table 3) and use less expensive outpatient care more. As you can see, early detection of potentially life threatening conditions results in low premature mortality and low hospitalization. Emergency rooms are used less because people have ready access to a doctor. Our people are healthier not because of unique genetics, healthy climate or high tech medicine, but because they have access to primary care.

Bringing basic health services to all of Americans will not only help to improve their health status but should work to reduce health care costs. Far from adding to the costs of the system, it will actually make the system less expensive.

This is suggested by our systems experience. Recent analysis of Hawaii's health care costs suggests that our costs for health care as a share of Domestic Product are closer to those of Canada, Germany, France and Japan than to that of the rest of the United States. Despite Hawaii's high cost of living, health care in our State is less expensive. I have attached this article (Attachment 1) for your committee's review.

#4. Using an employer mandate to cover a large number of the persons who would be otherwise uninsured, government can create affordable, responsive public coverage systems for the remainder.

Because Hawaii's gap group was reduced to 5% by Prepaid Health Care and Medicaid, we were able to initiate a State Health Insurance Program (SHIP) to provide subsidized insurance for the uninsured without breaking the State treasury. In SHIP, the individual shares in the cost of coverage. Our experience shows that people want the security of insurance and will help pay for their health care coverage. It also shows that people will invest in and use insurance which focuses on prevention and primary care and that such insurance can be cost-effectively provided in cooperation with the private sector.

#5. Hawaii shows that states are important actors in affecting health care reform.

Thanks to its ERISA waiver, Hawaii, though a small state, has demonstrated that an employer mandate can be successful in reducing the numbers of uninsured. Even the small number remaining has now been reached through our SHIP. Further, the voluntary efforts of Hawaii's two major insurers have produced health care coverage at costs well below other areas of America.

SUGGESTIONS FOR NATIONAL REFORM:

It is quite obvious from what I have said already that we do feel our system works well for Hawaii, providing universal access to high-quality services at costs which, while still high, are somewhat lower than the rest of the nation.

I also believe Hawaii has much to offer the national debate: important lessons from seventeen years of employer-mandated experience, from twenty-six years of administering Medicaid, and from recent implementation of a state subsidized insurance program for the remaining gap group.

Nationally, there have been many studies, reports and recommendations on how to deal with America's crisis in health care. These recommendations have focussed on two basic strategies: preserving the status quo or radically centralizing America's health care system.

The first continues the trend of more costly care for fewer people -- a recipe for disaster. The second centralizes decision-making, discouraging competition, incentives, and innovation.

Hawaii's experience supports a third strategy: a partnership with the private sector.

In this partnership, government establishes and enforces reasonable health care coverage standards, but encourages the competitive marketplace to achieve those standards in the most affordable manner.

This new public/private paradigm would join the community focus of public health with a new private health care system which would emphasize the importance of prevention and primary care. By guaranteeing universal access while retaining the best features of a private market place, America can provide top quality health care at reasonable costs to all our people.

Based on our experience, we believe a national plan should have the following 10 ingredients:

1. **A National Mandated Basic Benefits Package**

Americans must have early and effective access to all the health services needed to maintain good health. A basic benefits package containing needed services from prevention and primary care to hospital and catastrophic care, is the most basic requirement of a national plan.

2. **A National Health Insurance Employer Mandate**

An employer mandate is the best way for America to cover most of the currently uninsured. We would suggest that Congress consider re-looking at a simple "everybody plays" mandate, such as ours. This mandate should involve all employers and cover all employees working more than a set number of hours per week and their dependents. Such a mandate would ensure fair cost-sharing between employer and employee, and a minimum of "red tape."

3. **National Insurance Reform**

An employer mandate requires the availability of reasonably priced insurance. At a minimum, fair access to reasonably priced insurance should be guaranteed by community rating of the basic benefit package for small business and the prohibition of exclusionary insurance practices.

4. **A Cost-Containment Oriented Tax Incentive**

We need to restructure our federal tax policy to provide incentives to insurers and employers to offer and purchase cost-effective plans. For example, the federal health care deduction should reflect the cost of basic coverage, not unlimited coverage as currently structured and the self employed should be able to deduct the full cost of basic benefits. I suggest the tax revenues generated from coverage above the basic threshold go to funding system reforms.

5. **Standardized Claims and Encounter Form**

We are all well aware that administrative costs needlessly burn up health care resources. Standardizing the insurance package and all the forms involved in processing claims will reduce health care costs and enhance competition in the market place. With standardized information, providers and consumers will be better able to make cost-effective choices.

6. **Consumer Education and Information Sharing**

The true engine of cost control is a well informed health care consumer. Such purchasers need current and pertinent information on prices, outcomes, and consumer satisfaction. Thus, an open information system is a basic requirement of a national plan.

7. **Cost Containment Commissions**

I believe that organizing and empowering consumers is an effective cost containment strategy. I further suggest that we develop cost containment commissions with fair representation from all sectors of the community including business and labor to monitor and study health care outcomes and costs, consumer and provider satisfaction and regulate, if necessary, prices and budgets.

8. **Tort and Medical Standards Reform**

The complexities and subtleties of establishing "FAULT" or liability in our modern legal system is incompatible with the risks inherent in the practice of healing. As a society, we must come to grips with the policy question of how much risk we are going to allow or even encourage in the medical treatment of human beings. The present ambiguous state of affairs causes substantial direct and hidden costs. Therefore, any national health care reform must address both practice standards-of-care and the tort system.

9. **Coordination Between Public and Private Resources**

Presently public financing of health care is fragmented into many different programs for a wide variety of specific target groups.

I propose, instead, that public financing be reserved for safety net services for the medically indigent, including case management of difficult cases for those who are unable to use private sector resources effectively.

Furthermore, to end cost-shifting practices, reimbursement levels must be comparable to actual costs. This simplified system should be administered by the individual states.

10. **A National Mandate for Public Health and Prevention**

Prevention and public health measures, both of which have the potential to improve community health at low cost, are all too often ignored when funding is awarded -- eclipsed by specific programs for high visibility target populations. Our plans would set aside a portion of federal health expenditures to ensure that these efforts are adequately funded.

Finally, in addition to these 10 points, it is clear that unless we comprehensively address long-term care financing, we will be unable to provide access to our elderly and curb the cost of rising dependence on Medicaid.

In Hawaii, our Executive Office on Aging has taken the lead in developing the Hawaii Family Hope Program, designed to cover 80 percent of the cost of institutional, home and community-based, long-term care.

We are currently seeking federal authorization and demonstration dollars to implement this program and will be seeking waivers in the near future. There is a compelling need as Hawaii's elderly population is growing nearly three times as fast as the rest of the nation. Our initiative is driven by our need, and may well set an example for what is possible for the rest of the nation.

In closing, Hawaii's experience shows that health reform can be accomplished, while still maintaining the basic strengths of America's health care system. Regardless of the approach we take, ultimately, reforms must be rooted on these three principles:

1. Public health and prevention must be a priority to foster a healthier and more responsive society. Unless each one of us adopts responsible health practices, our health care needs will increase, wiping out the fruits of any cost containment efforts we may adopt;

2. Primary care, focussing on a community-based medical home for each citizen, must be the first priority and foundation of access efforts. Primary care is effective in lowering the need for more expensive care. It is vital that each of us has such a regular source of care, which will best be able to guide us through the complexities of the health care system.

3. Government doesn't need to run a health care system. Its presence in delivery of care, setting of reimbursements, or payments serves mostly to stifle the innate creativity which has made American health care the best in the world. Government does need to set and enforce rules by which a fair and equitable market place can operate.

I believe that awareness of and commitment to these principles will assure ultimate success to our health care reform endeavors. In any case, we all must move forward at both state and federal levels to achieve health care reform for America. Hawaii joins enthusiastically in this effort.

Thank you and ALOHA.

Attachments

TABLE 1

COMPARATIVE HEALTH INSURANCE PREMIUMS

SMALL BUSINESS GROUP INSURANCE RATES*, 1990

STATE	SINGLE	FAMILY
Hawaii	94	263
New York	360	360
Kansas	564	564
Delaware	240	516
Georgia	140	340
California	141	503
Iowa	139	313
Massachusetts	217	508

* Benefits among these plans vary, although they all represent comparable health plans. Please note that no two plans are exactly the same, and plan benefits should be considered before making any direct comparisions. For example, small business plans of the Continental U.S. tend to use other factors as part of their rating critieria, such as age, sex, occupation, and location.

TABLE 2

YEARS OF PRODUCTIVE LIFE LOST PER 100,000

DUE TO PREMATURE MORTALITY, AGE ADJUSTED

	HAWAII	U.S. POPULATION
Cancer*	684	871
Heart Disease*	523	699
Index of YPPL, 1987	2,345.3	3,126.6

* 1990, CDC

TABLE 3

UTILIZATION OF COMMUNITY HOSPITALS
1990

	HAWAII	% OF NATION	NATION
Beds/1,000 Population	2.6	70%	3.7
Patient Days/1,000 Population	809	89%	909
Surgery/1,000 Population	55.6	63%	88.1
Emergency Room/1,000 Population	200.2	57.5%	348.6

Source: Universal Health Care Almanac, Table 2.7.1, Silver and Cherner, Phoenix, 1991.

CHART 1

UNEMPLOYMENT PERCENTAGES FOR THE U.S./HAWAII

	U.S.	HAWAII
1970	4.8	4.9
1971	5.8	6.9
1972	5.5	7.7
1973	4.8	7.2
1974	5.5	7.9
1975	8.3	8.3
1976	7.6	9.8
1977	6.9	7.3
1978	6	7.7
1979	5.8	6.3
1980	7	4.9
1981	7.5	5.4
1982	9.5	6.7
1983	9.5	6.5
1984	7.4	5.6
1985	7.1	5.6
1986	6.9	4.8
1987	6.1	3.8
1988	5.4	3.2
1989	5.2	2.6
1990	5.4	2.8
1991	6.6	2.8

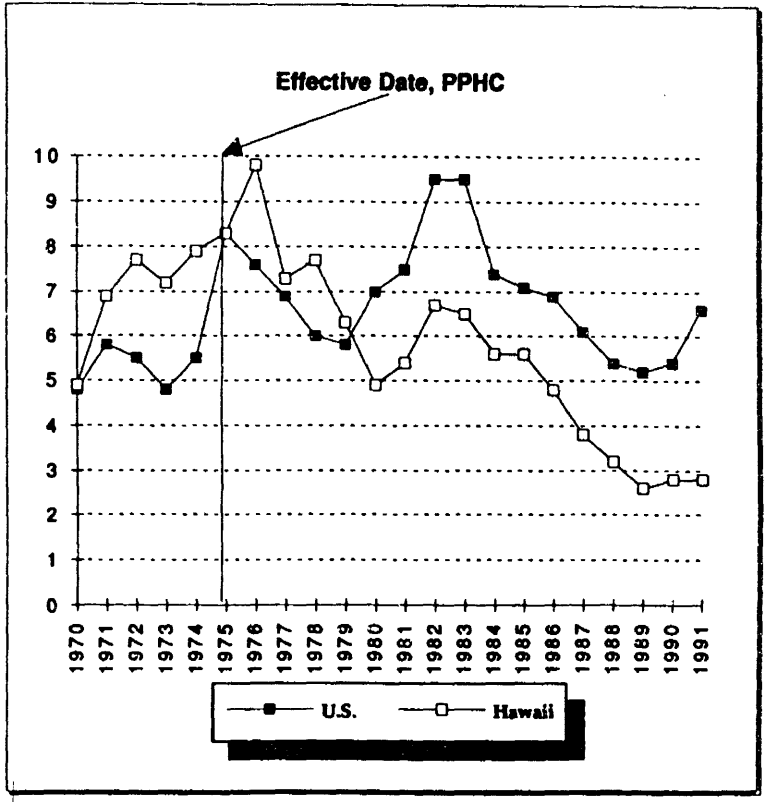


CHART 2

GROWTH IN EMPLOYERS

HAWAII 1970-1991

Year	Total Employers
1970	14427
1971	14695
1972	15482
1973	16475
1974	16907
1975	17762
1976	18240
1977	19109
1978	20140
1979	21033
1980	21739
1981	22079
1982	22441
1983	22523
1984	22930
1985	23294
1986	23839
1987	24636
1988	25083
1989	25758
1990	26588
1991	26877

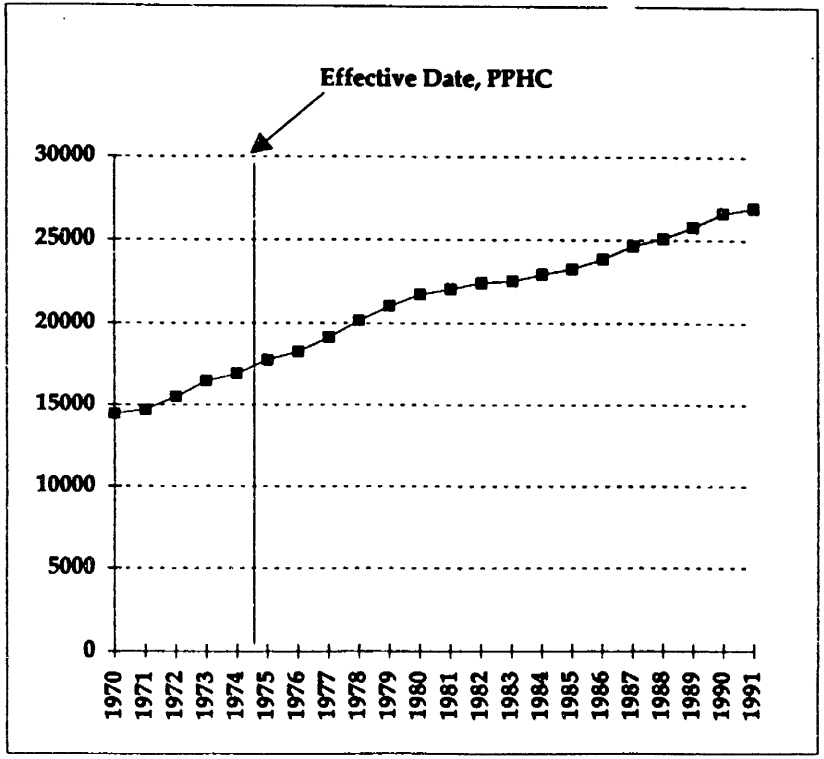


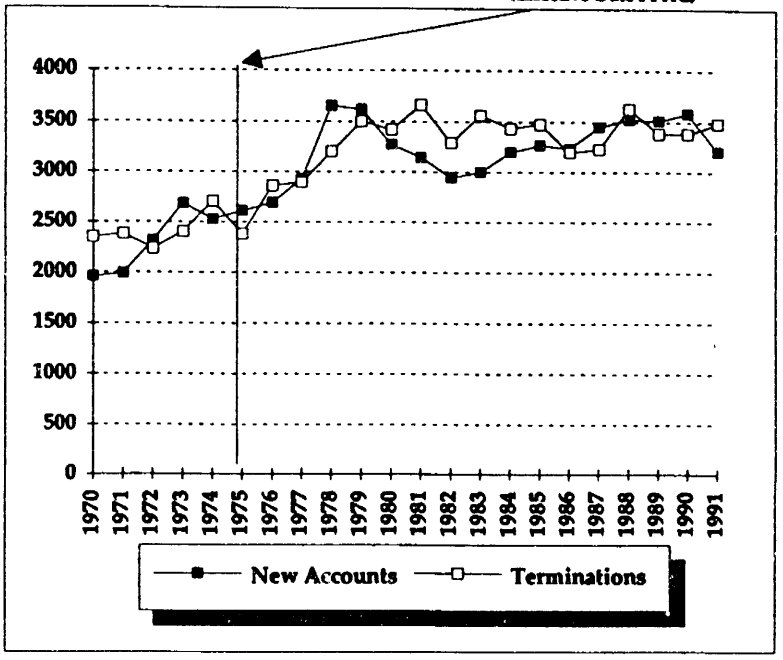
CHART 3

NEW EMPLOYER ACCOUNTS & TERMINATIONS

HAWAII INCOME SECURITY LAW

1970-1991

Year	New Accounts	Terminations
1970	1959	2352
1971	1989	2379
1972	2315	2240
1973	2686	2400
1974	2529	2706
1975	2610	2379
1976	2690	2864
1977	2931	2896
1978	3661	3206
1979	3621	[illegible]
1980	3276	[illegible]
1981	3148	3664
1982	2942	3294
1983	3001	3568
1984	3199	3437
1985	3269	3478
1986	3239	3200
1987	3453	3230
1988	3527	3633
1989	3514	3391
1990	3585	3585
1991	3214	3486



* *New Accounts - An Employer Newly Liable under the Hawaii Employment Security Law*

Terminations - Employers who are no longer liable under the Hawaii Employment Security Law

Comparison of health expenditures in U.S. and Hawaii economies

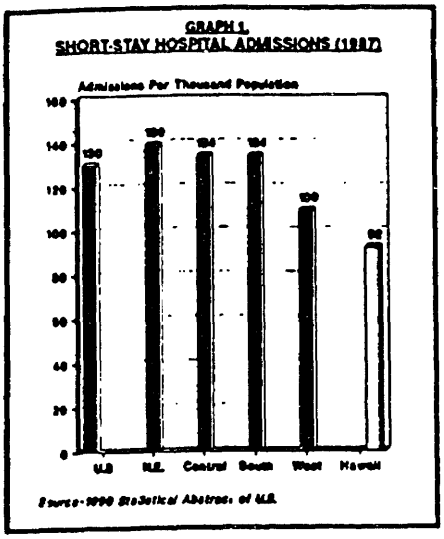
Richard V Stenson MHA MBA FACHE FACMGA

The author uses published statistical and economic data to demonstrate that Hawaii's health care costs, as a percent of gross product, are significantly below the U.S. average, perhaps as low as 8.1% of Gross State Product (GSP).

Introduction

Although a great deal has been written about the growing portion of the Gross National Product (GNP) being expended on medical services, there has been no comparative data published previously on the share of Hawaii's Gross State Product (GSP) consumed by health care expenditures. Further, since health care costs have been rising steadily in both Hawaii and the U.S., business leaders and government authorities here may well assume that Hawaii's costs are comparable to those on the mainland U.S.

Hawaii's health service providers believe that since the State is among the lowest in rates of hospital admissions and outpatient visits in the country (Graphs 1 & 2)[1], has far fewer hospital beds per population (Graph 3)[2], and hospital expenses generally below those of comparable, high cost-of-living states (eg California, New York, and Alaska[3]), the percent of Hawaii's GSP used to provide medical goods and services is presumed to be less than that for the U.S. as a whole.



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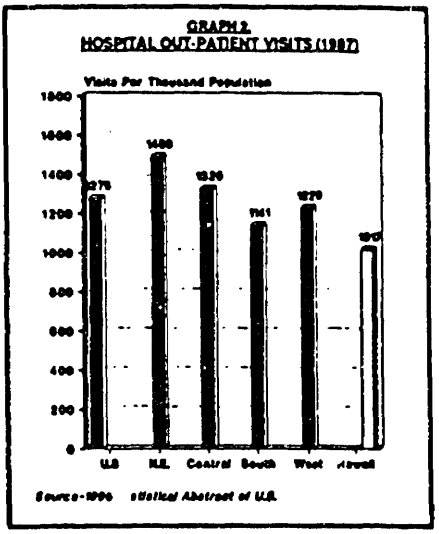
Methods

This paper compares the major medical economic data ele-



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COMPARISON (Continued from page 10)

ments in the U.S. and Hawaii. The sources of information are existing published data, primarily the Hawaii Department of Business, Economic Development & Tourism's (DBED) annual *Data Book* and the Health Insurance Association of America's (HIAA) annual *Source Book of Health Insurance Data*.

The HIAA data are produced largely from the federal Health Care Financing Administration's (HCFA) tabulation of Personal Health Care Expenditures (PHCE), whereas the State's DBED reports use the methodology of the U.S. Commerce Department's Personal Consumption Expenditures (PCE) — Medical Care component, as reported in National Income and Product Accounts (NIPA). There are minor differences in accounting methodologies used by HCFA and Commerce. As a result, the Commerce NIPA and related DBED figures have been somewhat lower relative to the HCFA tabulations. (HCFA and Commerce are working to resolve this problem in the next 2 years.) If this difference in methodologies is left unadjusted, the Hawaii data appears even more favorable (lower) than presented in this paper.

The following data and graphs compensate for this built-in understatement by raising DBED reported Hawaii figures by the same ratio of the difference between NIPA and HCFA medical care consumption accounts for each of the years cited (eg the effect for 1988 was to increase Hawaii's percent of GSP for medical care from 7.5% to 8.1%). These interpolations are based on the U.S. Department of Commerce's *Personal Consumption Expenditures Methodology Papers: U.S. National Income and Product Accounts*, June 1990, and issues of the U.S. Department of Commerce's periodical *Survey of Current Business*. Where minor data elements for Hawaii are unavailable, ie, net cost of health insurance, public health activities, research and construction (combined total less than 12% of total health expenditures), they are interpolated at national norms for those years.

TABLE 1

1988 HEALTH EXPENDITURE BY TYPE (Millions)

Type of Expenditure	U.S.	Hawaii*
Personal Health Care**	$478,000	$1552
Program Administration and Net Cost of Private Health Insurance	26,000	85
Government Public Health Activities	17,000	51
Total Services and Supplies	521,000	1,688
Research and Construction	19,000	64
Total Health Expenditures	$540,000	$1,752

* The Hawaii figures have been proportionally raised for an equitable comparison with national accounts, as noted in the preceding discussion.

** "Personal Health Care" represents private and public spending for direct health and medical services to individuals, whether insured or not. The figure includes items such as hospital, nursing home and home health care, physician, dentist, and other professional care, drugs and other medical nondurables, vision products and other medical durables; also included are nonprescribed drugs and medicines, household supplies and other items not covered by insurance.

TABLE 2

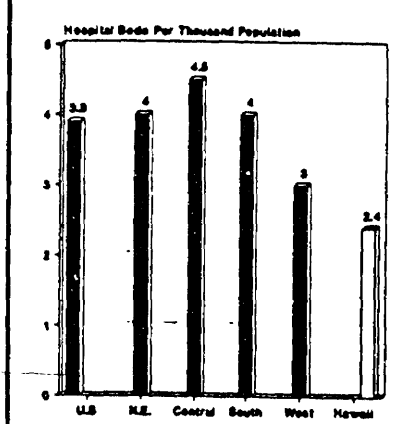
1988 U.S. AND HAWAII HEALTH EXPENDITURES (Millions) AS A PERCENT OF GROSS PRODUCT*

U.S. Health Expenditures / Gross National Product	$540,000 / $4,881,000	=	11.1%
Hawaii Health Expenditures / Gross State Product	$1,752 / $21,588	=	8.1%

Results

A comparison between U.S. and Hawaii health expenditures indicates that the percent of Hawaii's GSP consumed by medical goods and services was at 8.1% in 1988, versus the U.S. experience of 11.1% of GNP (Table 1, Table 2, and Graph 4). A review of data from prior years indicates this divergence began in 1983 and has increased since then (Graph 5). Graph 6 (per capita annual health expenditures in current dollars for both Hawaii and the U.S.) demonstrates that the ratio favorable to Hawaii is not simply an aberration of the rapidly expanding local economy (the GSP denominator in the ratio), but is due to a generally lower and slower rate of growth of the health care expenditures in Hawaii.

GRAPH 3.
SHORT-STAY HOSPITAL BED SUPPLY (1987)



Source-1990 Statistical Abstract of U.S.

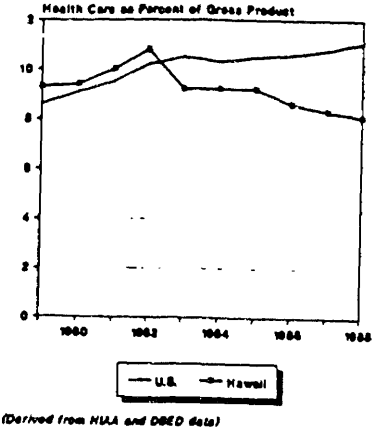
When compared to other industrialized countries with purportedly exemplary national health programs, Hawaii's health expenditures as a percentage of the economy are lower than in many. Graph 7 depicts the relative health expenditures as a percent of Gross Domestic Product (GDP = GNP less net foreign investment income), in the U.S., Canada, United Kingdom, Japan, Germany, Sweden, the Netherlands and Hawaii. Hawaii has the third lowest expenditure ratio in this comparison.

Discussion

The specific causes of this enviable cost of health care record in Hawaii have never been delineated. Many theories have been advanced to explain our favorable health status (greatest longevity in the U.S.) and lowest hospital utilization. The various factors mentioned include the mild climate, the multi-cultural population, an oligopolistic health insurance industry, a mandated workplace health insurance coverage, as well as the role of the State Health Planning and Development Agency (SHPDA), to name a few. To date, none has proven to be the primary element restricting our health service utilization and expenditures. This is worthy of further research, since the answer may be beneficial to other communities attempting to deal with soaring health costs.

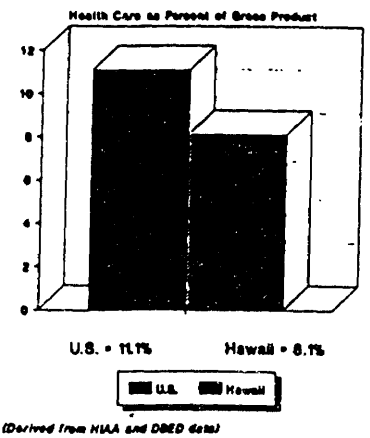
However, one wonders whether our overall health expenditures are lower, in part, because Hawaii's health providers are being paid less per unit of service than their peers in other communities with comparable high costs of doing business, as is frequently implied by anecdotal comparisons with Mainland counterparts.

GRAPH 5.
HEALTH EXPENDITURES AS % OF GNP AND GSP



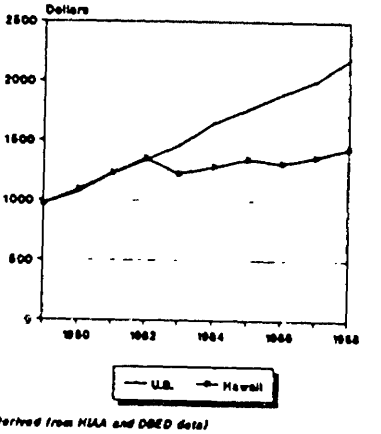
(Derived from HIAA and DBED data)

GRAPH 6.
1988 HAWAII VS. U.S. HEALTH EXPENDITURES



(Derived from HIAA and DBED data)

GRAPH 8.
PER CAPITA ANNUAL HEALTH EXPENDITURES



(Derived from HIAA and DBED data)

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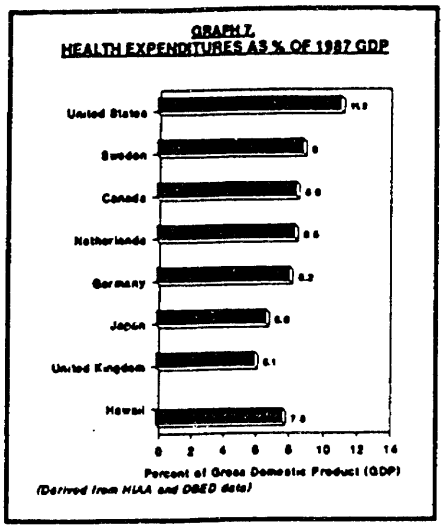
COMPARISON *(Continued from page 13)*



Conclusion

Health care expenditures have been rising inexorably all across the U.S., including Hawaii. Much has already been written about the causes of this growth, eg increasing consumer demand, aging population, advances in health technologies, scarcities of professional labor and general inflation. Nevertheless, this paper demonstrates that Hawaii's health care purchasing power, relative to other costs in our economy and the U.S. as a whole, is a proven better value to the people of our community.

Perhaps the State would be best served if the efforts of our community leaders focused on a comprehensive study of why Hawaii has done so well. In this way we might learn how to maintain and improve on this successful record, and transfer our experience to other states.

LEGEND AND REFERENCES

1. *1990 Source Book of Health Insurance Data*, published by Health Insurance Association of America (HIAA), page 78, Table 5.2, lists days of short-stay hospital care per 1,000 U.S. population for 1988 as 834. The Hawaii Department of Health (DOH) *1988 Statistical Report*, page 94, Table 7 lists average statewide acute care daily census (including Tripler Army Medical Center (TAMC)) as 2,073. The Hawaii Department of Business, Economic Development & Tourism's (DBED) *1990 Data Book*, page 14, Table 3 lists a 1988 *de facto* state population of 1,216,700. When 2,073 is multiplied by 366 days (a leap year) and divided by the *de facto* population of 1,216,700, Hawaii had 624 days of acute care hospitalization per thousand population for 1988.

   Graphs 1 and 2 use data published in the *1990 Statistical Abstract of the U.S.* 1987 short-term hospital admissions and out-patient visits (page 106) are divided by 1987 regional population figures (page 20) to create Graphs 1 and 2, respectively.

2. The DBED *1990 Data Book*, page 618, Table 719 ranks Hawaii 49th in hospital beds per population. The HIAA *1990 Source Book of Health Insurance Data*, page 64, Table 4.9 lists total U.S. acute hospital beds as 948,697 for 1988. The U.S. Department of Commerce, Bureau of Census, *1990 Statistical Abstract of the U.S.*, page 7, Table 2 lists the 1988 U.S. population as 246,329,000. Therefore, U.S. acute hospital bed per thousand population were 3.84. Whereas the DOH *1988 Statistical Report*, page 90, Table 1 lists Hawaii statewide acute hospital bed capacity (including TAMC) for 1988 as 2,855. And, the DBED *1990 Data Book*, page 14, Table 3 lists the 1988 *de facto* state population as 1,216,700. Therefore, the Hawaii acute hospital beds per thousand population were 2.35. Or, Hawaii was only 61% of the U.S. ratio of hospital beds to population.

   Graph 3 uses data published in the *1990 Statistical Abstract of the U.S.* 1987 short-term beds (page 106) are divided by 1987 regional population figures (page 20).

3. The HIAA *1990 Source Book Of Health Insurance Data*, page 64, Table 4.9 lists 1988 average costs per hospital stay (expenses) for each state. Hawaii average hospital cost per hospital stay was $4,651. Alaska was $5,616 per stay. New York was $5,070 per stay. California was $5,061. Nine states had higher average hospital stay costs than Hawaii.
4. U.S. value from HIAA *1990 Source Book of Health Insurance Data*, page 56, Table 4.1. Hawaii value from DBED *1990 Data Book*, page 349, Table 388 "1988 Personal Consumption Expenditures Resident Population, Medical Care: $1,441,000,000."
5. 1988 U.S. value for Program Administration and Net Cost of Private Health Insurance from HIAA *1990 Source Book of Health Insurance Data*, page 56, Table 4.1. Hawaii data unavailable, but estimated at same proportion (5.5%) of Personal Health Care as U.S. expenditures.
6. 1988 U.S. value for Government Public Health Activities from HIAA *1990 Source Book of Health Insurance Data*, page 56, Table 4.1. Hawaii data unavailable, but estimated at same proportion (3.3%) of Personal Health Care as U.S. expenditures.
7. 1988 U.S. value for Research and Construction from HIAA *1990 Source Book of Health Insurance Data*, page 56, Table 4.1. Hawaii data unavailable, but assumed at same proportion (4.1%) of Personal Health Care as U.S. expenditures.
8. 1988 Gross National Product from HIAA *1990 Source Book of Health Insurance Data*, page 57, Table 4.2. Gross State Product from DBED *1990 Data Book*, page 346, Table 385.

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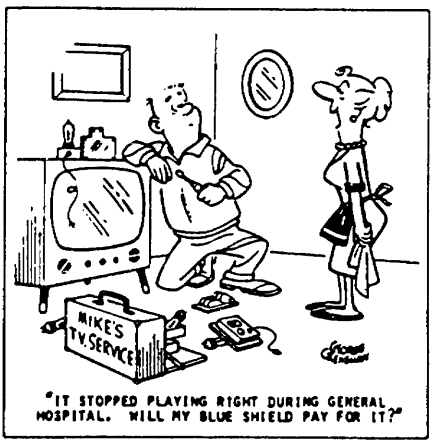

COMMUNICATIONS

ASTHO STATEMENT ON HEALTH CARE REFORM

ISSUE

The statistics describing the health system problems in the United States are compelling. The health care portion of our nation's GNP is on a rapid rise, projected to reach as much as 14 percent this year. In 1990 it was estimated that health care took 25 percent of American business profits. Per capita health spending in the United States is the highest in the world. Despite these expenditures, however, too few people are covered by basic health insurance. Of our tremendous expenditures for sickness care, too little is spent on prevention and early detection of disease and illness. Currently an estimated 34 million Americans are without health care insurance coverage either through private insurance, Medicaid or Medicare. In addition, approximately 20 million more Americans under age 65 reportedly do not possess adequate health insurance protection.

High medical expenditures have not consistently translated into improved quality of life or greater life expectancy. We know that health promotion and disease prevention efforts not only save lives, but also improve the quality of life. Yet currently, only an estimated 3 percent of our federal health spending goes to prevention activities. Data show that with improved efforts in the areas of prevention and primary care, this Nation can save lives and valuable health care resources. For example, the lifetime cost of caring for an infant struck with rubella is $200,000; for every $1 spent on immunization, $10 is saved. Teenage pregnancies cost the government more than $20 billion a year, yet a $1 investment in family planning services saves more than $4 in health and welfare costs. It costs $50,000, on average, before a low-birth-weight baby can leave the hospital but it costs only $4,800 for comprehensive prenatal and delivery care. It costs $15,000 a year to educate a child born addicted to drugs or alcohol but it only costs $3,000 per year to educate a healthy child. Prevention, primary care and comprehensive health education from kindergarten through grade twelve must be available to all individuals if we are to improve the health of our nation. Truly, an ounce of prevention is worth a pound of cure.

ASTHO POSITION

An effective resolution of the crisis in health care delivery will only occur with the development of a system of universal access providing a continuum of comprehensive public health and health care services, intended to assure the optimal health of all individuals throughout their lives.

ASTHO maintains that any health reform proposal must address prevention at its most basic level by ensuring that public health measures such as health promotion; disease prevention, including screenings, early detection, early care and treatment; epidemiologic services; and environmentally safe air, water and food supplies for all communities are included. ASTHO believes that the following areas must be the centerpieces of any effective health care reform package:

- Community-wide preventive health services
- Universal access to basic health services
- A guaranteed minimum benefits package with a strong emphasis on preventive health services, including health education
- Financial reform
- Strong cost-containment measures
- Quality assurance

ASTHO's policy also recognizes that reform of the health care system can best be achieved through a partnership of federal, state and local public health agencies, community-based organizations and the private sector to assure access to comprehensive community and individual health services.

ROLE OF PUBLIC HEALTH AGENCIES

Public health agencies contribute to the health care system at three levels: local, state and federal.

At the local level, public health's primary role is one of health promotion and disease prevention and may include direct care. The guiding principle is the provision of community-wide preventive services and promotion of health enhancing activities. This includes building networks with other providers such as private practitioners, home health care agencies, community health centers and city and county governments to see that community needs are being met. Activities also include community needs assessment based on local data and local policy development. Local public health agencies are concerned with community level issues such as access to appropriate providers, immunization goals and maintenance of a healthy environment.

> ASTHO's policy is that health care reform must build on these core public health functions and develop the capacity of local health departments to assure access to primary care services and where appropriate, to provide the services.

Public health services benefit everyone but often target high risk populations and low income disadvantaged groups. Even with universal health care coverage, there will still be families and groups, because of cultural, linguistic, geographic or other barriers, that will not have ready access to health services. Public health agencies are in a position to assist these disadvantaged groups in gaining access to the system.

> ASTHO's position is that the entire public health infrastructure, including local health departments, must be adequately funded in any health care reform to fulfill these revised and expanded public health responsibilities.

On the state level, public health agencies organize resources and coordinate public health services. State health agencies are responsible for the assessment, policy development and assurance functions for the health of the state's citizens. State health agencies maintain statewide data systems to track health status and outcomes of interventions. Plans for health care reform must incorporate the critical role of state health agencies in assuring the effectiveness of interventions to address the most pressing public health problems. Population-based prevention activities that extend beyond the boundaries of individual providers and facilities are necessary. For example, lead poisoning, vaccine preventable diseases, tuberculosis and infant mortality require community-wide public health services including outreach, screening, linkage to care, monitoring and education. State health agencies, working with all available public and private resources, perform these linkage activities and, additionally, often serve as service providers of last resort. Fundamental public health services both for individuals and communities must be available to the entire population.

ASTHO's position is that these important resource development, capacity building, linkage activities and, where needed, service delivery functions must be an integral part of any "new" health care system.

The federal role in public health is to provide national leadership for health promotion and disease prevention, to assist with financial resources, grants-in-aid and technical assistance, to provide regulatory direction and to also act as a research arm. The federal government also supports health professional training and placement programs in an effort to ensure an adequate number and distribution of primary and preventive care professionals.

ASTHO's position is that the continuance and expansion of public health service and training programs by the federal government, through all appropriate federal agencies, remain crucial parts of a healthy America.

ASTHO recognizes the unique responsibility of public health agencies to place reform activities in the broader context of the health of the public and of communities as well as individuals. Their focus on the community and their emphasis on education for healthy behavior should place public health agencies in a position to assist in shaping the policy direction of health care reform.

UNIVERSAL ACCESS TO BASIC HEALTH SERVICES

ASTHO's position is that a nationwide system of health care must provide a continuum of services which are comprehensive and universally available. An essential set of services must address the continuum of care which represent all stages of health needs. These include disease prevention and health promotion, clinical preventive services, primary care and acute care.

In order to provide truly "universal access," health reform must address not only financial issues but issues such as availability of providers, geographic barriers to care and development of ethnically, culturally and linguistically appropriate health systems. True reform must also address the huge burden of inappropriate and unnecessary medical procedures, which have created a major drain on health care spending, and must re-focus financing on preventive and primary health care services. Although not discussed here, ASTHO recognizes another stage of health care needs, long-term care, which must also be addressed in health care reform.

DISEASE PREVENTION AND HEALTH PROMOTION

The first stage, disease prevention and health promotion, including health education, represents the traditional role of public health professionals. Environmental and behavioral improvements have caused our most dramatic

gains in overall health in the last 100 years. Health promotion and protection services are the most humane and cost effective services the health system can provide. The target audience for disease prevention and health promotion is the general population. However, health promotion and disease prevention efforts have been inadequately funded and reimbursed, and worse, overlooked as essential components of effective health systems. This is in spite of the fact that it is often failure to address prevention issues that results in the need for higher cost therapeutic health care services.

CLINICAL PREVENTIVE SERVICES/PRIMARY CARE

The second stage of health needs, clinical preventive services and primary care, bridges the gap between public health activities of health promotion and protection and acute care treatment of illness. Clinical preventive services include prevention services targeted to individuals as well as early identification of disease processes. Comprehensive primary care is the cornerstone for the development of effective and efficient systems of personal health care. Primary care should be the hub from which other health services, including specialty referrals, acute hospitalization, long-term care and in-home care are coordinated. Clinical preventive services are viewed as an integral part of comprehensive primary care. Access to clinical preventive and primary care services is critical to meet health needs at this stage.

ACUTE CARE

Individuals must be guaranteed access to acute care, which includes traditional inpatient and outpatient hospital services as well as hospice services.

An important factor for each of these stages is access to continuous medical therapies and services. This includes the ability of individuals to receive necessary long-term preventive and rehabilitative interventions such as pharmaceuticals, health care devices and therapy services which will allow individuals to continue with, or return to, productive and healthy lives.

MINIMUM BENEFITS PACKAGE

> ASTHO's position is that all health benefit packages should address all stages of health care needs with the goal of assuring the optimal health of each individual and the community. These include disease prevention and health promotion services, clinical preventive services and acute care services.

DISEASE PREVENTION AND HEALTH PROMOTION

Assuring disease prevention and health promotion services is a responsibility of both public programs and private insurance. Disease prevention and health promotion services include assessment of community-level health status to identify problems and priorities, education services, including outreach efforts, and community level interventions such as implementation of public health programs. To the extent possible, these interventions should be provided in linguistically and culturally appropriate contexts. Providers of these services include not only physicians but other health care professionals including social workers, nurses, dental health professionals, nutritionists and physician assistants. Reimbursement for health disease prevention and health promotion care

services must be redirected to not only recognize physicians as providers of care but to support the practice of a variety of other providers, including certified nurse midwives, nurse practitioners, physician assistants and others, in teams and individually, as appropriate. ASTHO recognizes that organized health delivery systems such as managed care can be utilized to provide comprehensive care while increasing flexibility in reimbursement and reallocating resources to clinical preventive services.

> Individual health promotion and disease prevention services should be reimbursable services under individual health insurance benefits packages. The public health infrastructure must be supported by federal, state and local funds to continue outreach to underserved communities and to fill gaps in providing community-wide health promotion and disease prevention information and services.

CLINICAL PREVENTIVE SERVICES

Clinical preventive services benefits should include primary preventive services aimed at preventing occurrence of disease and disability and secondary preventive services aimed at early detection and intervention. The basic set of services should include those recommended by the U.S. Preventive Services Task Force in the Guide to Clinical Preventive Services. The Task Force recommended appropriate clinical preventive services for all members of any given age/sex group and other targeted services based on risk factors of an individual/subpopulation.

Specific services must include at a minimum:

- childhood immunizations
- prenatal and maternity care
- family planning
- mammograms
- pap smears
- cholesterol screening
- colon screening
- adult/elderly vaccinations
- limited dental health care
- adult and child preventive health visits

ACUTE CARE SERVICES

Acute care services must include treatment requiring attention, either outpatient or inpatient, from appropriate health care professionals.

> Covered procedures should be deemed to be medically necessary by the individual's primary care provider based on a set of commonly accepted standards for medically effective services and must discourage excessive use of high cost services. Access to advanced levels of care should be based on a process of prioritization.

A comprehensive set of data on health services outcomes and population health status must be required to evaluate experiences and to set priorities for future health care investments. Services provided through managed care programs, which link clients to primary care providers and promote appropriate use of services, should be encouraged.

FINANCIAL REFORM/MEDICAID

As long as Medicaid is the major health funding source for low income and many disabled people, reform of this system is critical. Health care reform may change the current Medicaid system or replace it with a new program.

> Regardless of the system, it is ASTHO's policy that new provisions and changes must provide states with the flexibility to confront the most pressing issues facing the state's population without being constrained by federal mandates.

Eligibility for Medicaid, or any other public program, should be based solely on income and assets, without categorical restrictions. This income eligibility should be disconnected from AFDC and SSI so that states can cover persons who may need financial assistance only with medical cost. Reasonable cost saving mechanisms, such as managed care, should be encouraged under Medicaid or any other public system.

In the absence of universal coverage, reforms should emphasize giving states the option of adding or modifying services and categories to better meet the needs in each state. States should also have the flexibility of offering a smaller benefit package for "new" groups of eligible persons as long as core services provided are consistent with the minimum benefits package.

State flexibility through programs like the Medicaid waiver process should be simplified and expedited, with emphasis on health outcomes rather than process. An activity approved under a waiver for one state and proven to be cost effective should be approved expeditiously in additional states.

The minimum basic benefits guaranteed by private insurance under a reform plan must also be the minimum guaranteed by the public system.

Payments to public and private providers should reflect the true cost of effectively providing services. Any public or private provider delivering services should be eligible for equitable reimbursement as long as services are provided in an efficient and cost-effective manner.

Federal law should be amended to permit state Medicaid agencies to report state-reportable diseases to the official public health agencies.

Finally, health system reform needs to ensure that federal requirements for state financing of medical and long-term care do not hamper a state's ability to adequately provide universal access to basic preventive and primary care services.

FINANCIAL REFORM/INSURANCE

Insurance market reform is another necessary part of universal access and cost containment. The Federal government should take the lead in implementing insurance market reforms that encourage insurers to provide policies which are concentrated on cost effective provider arrangements and care management.

> ASTHO's position is that specific reforms should be implemented to 1) eliminate cancellations or nonrenewals of coverage, 2) cap annual rate increases, 3) encourage coverage of lower cost alternatives to inpatient services such as home health care and outpatient services, 4) eliminate administrative waste by creating a uniform claims and billing system and 5) provide for portability of benefits between jobs. ASTHO also supports the elimination of health status and preexisting conditions as a determinant of insurance eligibility and establishment of community ratings, if universal access to health insurance is implemented.

Effective reform must also include provisions which encourage consumer responsibility. These provisions must not hamper an individual's ability to receive needed care. In the absence of national reform, modifications of ERISA are essential to allow states the capacity to undertake reforms, including the flexibility to impose employer mandates as part of state health reform efforts.

COST CONTAINMENT

Cost containment is one of the most critical areas to be addressed in health care reform. The centerpieces of universal access to care, a guaranteed minimum benefits package with a strong emphasis on prevention, recognition of each of the stages of the continuum of care, changes in the public system, insurance reform and consumer responsibility are all fundamental parts of cost-containment.

Systems of capitation, in combination with coordinated care, can reduce inappropriate use of emergency rooms, hospitalizations and other institutionalized care and can support the reallocation of resources into the strengthening of primary care.

Also important to cost containment are the development of policies to moderate the rate of growth in acute and tertiary care services and to promote growth in primary care and prevention programs. Strategies to reduce the rate of capital investment in duplicative services, technologies and facilities within defined geographic areas are needed. ASTHO supports federal policies which direct a larger share of health professional training resources, including a substantial redirection of Medicare Graduate Medical Education expenditures, to train primary care and preventive health service providers rather than specialty care providers. ASTHO also promotes development of policies that encourage and support those primary care providers willing to practice in underserved areas. Finally, ASTHO recommends adoption of policies to translate the benefits of modern technologies, practice efficiencies and outcomes research into lower consumer prices.

Cost containment efforts must be clearly linked to careful monitoring of health outcomes in order to assure continued high quality health care.

Critical Elements to Cost Containment

- Universal access to care
- Systems of capitation
- Moderation of the rate of growth in acute and tertiary care
- Growth in primary care and preventive services
- Reduction in the rate of capital investment in duplicative services, technologies and facilities
- Re-focus of health professions training from specialty training to primary and preventive health service providers
- Translation of modern technology and practices into lower consumer prices

QUALITY OF CARE

ASTHO supports efforts to measure and improve patient outcomes as a goal in health care reform. ASTHO supports funding for research to define parameters to measure quality of care, including the quality of public health interventions. Monitoring must assure that all individuals, regardless of source of payment, receive quality services at a uniform level consistent with the minimum benefits package.

State and local public health agencies are responsible for assuring the health of all citizens through monitoring of health status, access and outcome data; the role of public health agencies in monitoring and assuring quality care must be supported in all health reform proposals.

ASTHO believes that it is critical for each of the above areas to be addressed in any health care reform proposal. Without inclusion of these recommendations, America will continue to struggle for its health. ASTHO's Statement on Health Care Reform was adopted at the Association's annual meeting, May 20, 1992.

5/20/92

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