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HEALTH AMERICA: AFFORDABLE HEALTH CARE FOR ALL AMERICANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

ON

S. 1227

EAST LANSING, MI
SEPTEMBER 6, 1991

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HEALTH AMERICA: AFFORDABLE HEALTH CARE FOR ALL AMERICANS

FRIDAY, SEPTEMBER 6, 1991

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
East Lansing, MI

The hearing was convened, pursuant to notice, at 10:10 a.m., in Kellogg Center Auditorium, Michigan State University, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[Press Release No. H-36, Sept. 3, 1991]

SUBCOMMITTEE FIELD HEARING PLANNED FOR LANSING, MICHIGAN, SENATOR RIEGLE SEEKS COMMENTS ON HEALTHAMERICA PROPOSAL

WASHINGTON, DC—Senator Donald Riegle, Chairman of the Finance Subcommittee on Health for Families and the Uninsured, announced a hearing in Michigan on his HealthAmerica legislation.

The hearing will be at *10 a.m. Friday, September 6, 1991* at Kellogg Center Auditorium, Michigan State University, South Harrison Road, East Lansing.

"HealthAmerica will bring about comprehensive reform of the nation's health care system. The purpose of this field hearing is to hear the views of Michigan citizens about HealthAmerica," Riegle said.

The legislation, S. 1227, would provide that every American has basic health insurance coverage, either through a plan provided by an employer or through a federal-state public insurance program, called AmeriCare, that would replace Medicaid for acute care services. It also includes a program to control health care costs and provisions to reflect the special needs and problems of small business.

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

Senator RIEGLE. This committee meeting will come to order. Let me welcome all in attendance this morning and indicate that this is a formal hearing of the Senate Finance Committee, the Subcommittee on Health for Families and the Uninsured.

We will be making a transcription record of all testimony given today and we will be inviting any comments that anyone wants to submit for the record—those that were not scheduled to give oral testimony.

I want to invite your comments, observations, and information that you may have for us that bears on the subject that we are here to talk about today. We will make those statements a part of this committee record.

So, I want everyone here to know that we invite your direct participation, in addition to those who will speak later and who I will introduce at a later time.

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

Senator RIEGLE. I want to begin this morning by thanking Michigan State University, the Human Health Programs and Governmental Affairs offices here. And I particularly want to thank the president of Michigan State, John DiBiaggio, who is here, for his hospitality and courtesy in having us come.

He has a background in professional medicine, has a great interest in this subject, and I am delighted that he is here. I want to invite him to come forward at this time. I do not have my glasses on, so I cannot see exactly where he is. Here he is.

Mr. DIBIAGGIO. You can see this far.

Senator RIEGLE. Well, I know. I did not know if you were in the back or the front, but please come on up. We would certainly welcome comments from you at this time.

Mr. DIBIAGGIO. Can you see me now, sir?

Senator RIEGLE. I can, yes. [Laughter.]

I think we better make sure we have got eye care in this health program. [Laughter.]

STATEMENT OF JOHN DIBIAGGIO, PRESIDENT, MICHIGAN STATE UNIVERSITY, EAST LANSING, MI

Mr. DIBIAGGIO. Well, sir, we just want to tell you how pleased we are to host this particular hearing—a very important and critical hearing, I think, to all of our citizens. Not just to those who are users of the health care system, but those of us who are providers and those of us who are employers who face some very, very critical and important challenges in these very demanding times.

I am not only a university president, as you know, but also a member of Pugh Commission on Health Professions, so I have very special personal interest in hearing this testimony.

But, in addition, of course, I am gravely concerned—as are all Americans—about the cost of health care, the escalation of that cost. Here at Michigan State University where we have some 10,000 employees, for instance, our health care costs went up 1 year, 2 years ago by 35 percent.

And in attempting to deal with that in a fiscally strange time, we had to make some very, very serious other decisions at the university which damaged us, I think, in many, many ways. And so, indeed, it is important to us.

But I think it is equally important to the citizen who is a user who fortunately recognizes the fact that while we are investing a great deal in health care, the statistics seem to indicate that the quality of health in our country is less than it is in some other countries. And that is, indeed, due to the fact that so many people cannot access the system itself.

And so, what you are doing is very important and we want to thank you, Senator, and your colleagues, for having attempted to address this important issue. We look forward to hearing your tes-

timony and we thank you once again for allowing us to serve as your host.

Senator RIEGLE. Thank you very much, Mr. President. Nice to see you. [Applause.]

As one who was a student here at one time and earned an MBA degree and had a chance to do a little teaching here, I have a great fondness for Michigan State.

So, I am just delighted that we are here and I thank you for your comments. I am struck very much by your observation as to how the costs at Michigan State, just for the 10,000 or so employees that are associated with the University, have gone up so sharply with respect to health care coverage.

It is clearly part of the problem that we are attempting to address, and we will hear some things about that this morning from some of our witnesses with respect to problems they are facing and how we think that might be dealt with.

We are here today to gather official comment and reaction to this health care proposal that I have developed, together with three other Senate colleagues: Senator Rockefeller, Senator Mitchell, and Senator Kennedy.

This bill, S. 1227, is a comprehensive health care proposal that will, in stages over time, provide health insurance coverage for every citizen in our country.

And, at the same time, a profound and connected importance is that it will carry out a series of cost-saving measures, cost control and reduction measures that can bring about a much greater economic efficiency in our health care system.

These twin goals of a more economically and financially efficient system, and one that provides coverage to all of our people, is the goal of this legislation. That is what we are seeking comments and reaction to today.

I might say that this proposal was developed largely on the basis of input and commentary from citizens in Michigan. We had a number of hearings around the State of Michigan. We had a number of witnesses testifying.

One, particularly, Cheryl Eichler, who was a person suffering from Crohn's disease, was one of our most important witnesses. Her sister, Luann Nunnally is here today with her husband. Cheryl, some months after she testified, died.

I am convinced that had she gotten the health care that she needed at the appropriate times in her circumstance, she would be alive today. That is true of any number of other people, including those today who need help and who may not get it unless the reforms are made to see to it that health care coverage is available to everyone.

I want to draw attention in that regard to a story that some of you may have seen in yesterday's Detroit News newspaper. And it tells a story of a woman named Cynthia Fyfe, 36 years old, a single parent. And you can see here in the picture, she has with her her 6-year-old son Anthony—a little fellow here with glasses on. The story is to the effect that, well, she is working, and has worked very hard to be self-supporting. She has limited health care coverage for herself.

Nevertheless she has accumulated over $3,000 worth of medical bills that she is unable to pay. She has some serious medical problems that are continuing, and so, presumably, her bills will increase. Part of the story focuses just on the issue of her inability to meet her own health care costs.

But perhaps even more significantly than that is that her 6-year-old son has no health insurance coverage at all; none. And because she is working and he is not covered under her policy, there is no provision in our system today for this little fellow, or other children in similar situations to receive health care coverage for the health care needs that they have.

Now, we have to ask ourselves the question, "what is going on in America that that kind of a situation exists, even for a single day, and even for one person, whether it is this little tyke or somebody else?" We have a million people in the State of Michigan this day who have no health insurance, and something on the order of 35 to 40 million people across the United States who have no health insurance.

They need health insurance. As a nation, it is fully within our reach to craft a system whereby we can provide a measure of access to health insurance and health care for all of our people.

We attempt to do this in this legislation in terms of phasing in coverage for everyone throughout our society, and we start in the first phase by covering expectant mothers and children under the age of 19, which would reach this particular case, and many others like it. I will come back to that just a little bit later.

So, today we are here for the purpose of gathering more specific input and reaction to this legislative proposal, and any other suggestions that others care to make on this issue.

I want to just refer briefly to some background information that will put this into context and will relate importantly to some of the comments that president DiBiaggio has mentioned here. If you look at this chart all the way over here to the left, it lists down the side of the column various countries in the world starting with the United States at the top.

Public opinion polls show the percentage of people in each of these respective countries who think that the health care system is working well. Then they show how much each of those countries is spending per capita on health care.

It is really quite a striking contrast, because you will see, for example, in the top line in the case of the United States, 10 percent of the people who were asked this question in our society think the health care system is working well, which is a very low percentage by any measure.

And yet, our expenditures per person in the United States are higher than they are in any other country. We are spending—as of the time this was done 1990—over $2,000 a year per person. We spend over $700 billion a year and over 12 percent of our gross national product on health care way above that of any other nation.

As you go down the list through the other countries—Canada is at the bottom; you see Japan and Great Britain and others on the list—the percentage of support by the citizens of those countries for the systems that they have is far higher than here.

Yet, you will see their expenditures are substantially below ours. Even in the case of Canada, which has a more ambitious kind of a national health care program. Their figures per capita would run something under $1,500 a year, versus our figure in excess of $2,000.

Although it is significant that Canada, at the time that survey was done, was getting a 56-percent approval rating from their citizens, as opposed to the 10 percent in the United States.

These problems end up affecting everyone. Not just those who lack insurance or those who have it that are seeing their rates go through the ceiling. We are finding that the pressure on hospitals and on the health care system has become very extreme.

I asked the General Accounting Office to do an analysis of what is happening to emergency rooms and trauma centers across the country. They have done that and have come back with a report that shows that in the last 3 years, we have had 60 trauma units throughout the United States close because of the influx of people without any health insurance. Extreme and expensive health care needs need help, must be helped, and there is no way, presently, for those bills to be paid in any direct fashion.

In Michigan alone last year, hospitals lost $350 million on uncompensated health care that they provided on that basis. Now, that is a quarter of a billion dollars, and that is one State—in 1 year.

So, this problem is beginning to bear down so hard on just our structure of delivering medical care that it is one more reason why the urgency requires a change in this situation.

With respect to the impact on business, we will hear from some witnesses from businesses today. I want to draw your attention to the second chart here. We are a State that builds automobiles. We are not building and selling as many today as I wish we were.

This represents a comparison of data that the Chrysler Motor Car Co. provided us with that shows the difference in health care costs per car manufactured here in the United States versus the health care costs per car manufactured in other countries. And you will see, for example, at the time this analysis was done—that it is actually worse today. This was done some time back.

As you can see in that illustration, Chrysler was spending $700 per car on health care coverage for its employee work force. Whereas in France, the comparable figure was $375. In Japan, only $246. And significantly, in Canada, was $223.

The reason Canada becomes particularly relevant in the case of Chrysler is that we have a situation in Canada where Chrysler can produce cars in the United States, in the Detroit metropolitan area, say, or they can go across the Detroit River into Windsor and produce those same vehicles in plants in Canada.

With all other things being equal, there is a financial incentive for them to move production and jobs out of the United States into Canada or to other countries. In part, because of this enormous differential in health care costs, which, of course, have to come back into the total product cost and get built into the price of the car.

Seventy percent of the small business in this country with employees of 25 or less today are offering health insurance for their

workers, making a tremendous effort to do it despite high rates of insurance.

No business in our country can continue to labor indefinitely under those enormous cost disadvantages in this new global economy without great damage being done to those companies, and eventually to our job base.

In that respect, I want to make a reference to a couple of other articles in today's paper, then try to conclude.

Today in the front page of today's Detroit Free Press, down at the bottom there is an article that says, "Jobs Vanish in northern Michigan: Boyne City plant to lay off 289 workers."

The thrust of this story is that there has been a very dramatic shrinkage in jobs throughout the State of Michigan. It is now being felt very severely in the outlying areas, not just in the major manufacturing centers like Lansing, Detroit, Flint, or places of that kind.

But this now deals with the outlying communities, particularly in northern Michigan. It points out that for the first 7 months of 1991, Charlevoix, Emmett, and Antrim Counties—in northern lower Michigan—lost 405 jobs. That constituted 7 percent of their manufacturing jobs that have disappeared.

These are not lay-offs, these are permanent job reductions. These are jobs that have vanished. This condition is being accelerated and is working back and forth. Because, as people lose their jobs, they almost always lose what health care coverage they have. So, that creates one kind of a problem.

On the other hand, if the firms that are attempting to operate are finding that the cost of production—and particularly of health care costs—are so large that that is part of what is causing those businesses to fail, or to close down, or to go overseas, then it is the same problem hitting us in a different form.

It is a vicious cycle that is coming around and it argues very strongly for a need for us to make sure that access to health care is available to all of our people. Particularly those going into this enlarging pool of unemployed workers, to see to it that we are rationalizing the system and keeping the costs down so that we are not shutting businesses down because of skyrocketing costs and this cost shifting from all of the uncompensated care that we are seeing throughout the system.

Let me just quickly finish here. In this bill, in addition to the coverage that we phase in over a 5-year period to bring basic health insurance coverage to every person in the country, we have a very direct and specific effort to deal with this huge increase in cost to get the cost down. We are going to hear some ideas today and some reactions to the cost reduction part of this program.

We aim our bill in the direction of reducing unnecessary care, decreasing administrative costs, and restricting health care price increases. We think we can make health care more affordable for employers who are already providing coverage by controlling these costs.

That includes the burgeoning costs in medical malpractice insurance where many doctors are moving out of higher risk specialties because literally, they feel they cannot continue to absorb unconscionably high malpractice insurance policies.

At present, my wife is 4½ months pregnant. The obstetrician that delivered Ashley, our 6-year-old, has gone out of the practice of obstetric medicine because, as he explained to me, finally the cost of medical malpractice insurance in his field became so excessive, that he just did not feel he could continue his practice of medicine. Obviously, we, like many others, have had to shift to another doctor.

We feel that in our program we can save an estimated $80 billion over the next 5 years. We see those cost savings coming roughly in this pattern. We think there is that much to be saved by a rational application of sensible and fair cost control efforts of the kind that we have laid out here.

Now, as to the cost of the program. First of all, I think health care for our people is the best investment we could make. I think we will save far more money than we will spend. For a country to succeed and to thrive and to do well today in this global economy, you have to have healthy people who are employed in good jobs.

But you have got to have healthy people; you have got to have people who can get their health care needs met in an economically efficient manner, and then, of course, have an economy that can absorb them so they can go out and work and provide for themselves and for their families.

In order to get this program started, the estimate is the cost for the first year would be about $6 billion. Now, how much is $6 billion? If you put it in the context of the entire Federal budget for this year, the Federal budget this year is $1.4 trillion.

So, $6 billion in relationship to the entire Federal budget is less than one-half of 1 percent. It is not an insignificant amount of money by any means, but it is entirely within our financial capacity to meet that kind of an expenditure in the first phase to move this coverage out to cover expectant mothers and children from the age of 19 down. To get health care coverage established for that group in the first phase would be accomplished by that expenditure of $6 billion.

Now, I was struck the other day because we were talking about, with the enormous changes in the Soviet Union and the situation that is going on with respect to the change of the defense picture in the world today, a single B–1 bomber costs $1 billion. That is to build just one of them; to build six of them costs $6 billion.

Some of the choices that we are going to have to make as a country is to decide, on the one hand, whether little fellows like this who this minute have no health insurance in this country, are worth providing health insurance to, and covering them so they can be healthy and grow up and live good, solid, productive lives, or whether we are going to spend that money on other things that, in my view, are far less important and do far less to secure our future than the question of how our people are doing.

So, we can afford to do it. There will be some that argue that we cannot. Usually those are the people that have health insurance. In fact, the other day I had an opportunity to speak to the President about this. I was invited down to the White House to meet with him on another issue, and we had a good discussion on a broad range of issues.

And I took with me the testimony of Cheryl Eikler when she testified before our committee. And Cheryl, who, in my view, was saint-like, explained how, in her case, with her Crohn's disease, as I mentioned before, she was working at a 7-11.

She was earning $12,000 a year. She had no insurance at work, and because she was working, she was not eligible for any public assistance programs. Her bills for 1 month toward the end of her life were running $34,000.

Her testimony is so powerful because she was describing the great pain that she would be in, and she would be in and she would be afraid to go to the doctor for help because she did not know how she was going to pay the bills. Her case is not uncommon.

I asked the President to read this testimony, because he has a son with Crohn's disease, and I thought it would help drive home the reality of what this is like for individuals and families where there is no health insurance.

Also, I asked the executive branch to get moving on a health care plan that we could work together on. We could work out whatever differences we have and get a plan in place so that we could see that people's health care needs would be met. He said he would think about it, and that he would take a look at it. I trust that he has, and will.

But we have got to build up a much greater sense of urgency about moving this problem forward. I am convinced today that if the health insurance coverage for the top leaders of our government were to be taken away suddenly; if the President and his family lost their health insurance coverage; if those in the Senate did, and the House; and the Vice President and the Cabinet Officers, I have asked myself the question: how long would it take before there would be a proposal presented to the Congress to reestablish that health insurance coverage? My guess is probably within hours we would have a proposal. We could have a proposal within hours with respect to the country as a whole.

In fact, we have a proposal, and it is right here. It is a pretty darn good bill. I do not say it is perfect. Not everything that I would want, because it is the product of compromise, even with my three co-sponsors. I am open to changing it. I think the two parties need to work together—the executive branch and the legislative branch—to refine the final product.

It is time to get it done, and it is time to make sure that our people throughout the country have access to the health care coverage that they need.

Finally, after this hearing today, we are going to be having two hearings in Washington later this month on the 23rd and on the 30th. I hope you will follow what is said at those hearings. We will be drawing national witnesses in from across the country.

But this is our first hearing since introducing the bill, and so this will be the first body of testimony that we will be receiving directly in response to this that gives us suggestions, and constructive criticisms, comments, the points that you wish to make to us.

Let me now introduce the witnesses that we are going to be hearing from, and we have actually three different panels, if you will, of witnesses, all of whom are seated here now, that you will be hearing from this morning.

I am going to give you a little information and introduction on our first three witnesses. I will call on them in order to speak. After they have spoken and any questions that go back and forth, then I will move to the next set of witnesses and I will introduce them at that time. So, let me now introduce our first three before calling on the first one.

The first person you are going to be hearing from is seated down to your far left, that is Kim Cameron, who has come to us from Lapeer, MI today. She is 26 years old. She, like Cheryl Eichler that I referred to, suffers from Crohn's disease.

Because of her illness, Kim has been able to work only periodically, and recently has been unable to work long enough to qualify for health insurance benefits through her employer.

She has been refused private coverage, and this is what happens so often in our society is that people are told that they, because of a pre-existing illness or pre-existing condition, cannot have coverage. Just cannot have it. It is there for others; not for them.

So, she has been refused private coverage, and she was turned down when she applied for Medicaid. Because she had no health insurance, she, like many others in her situation, has avoided seeking medical care for her condition. A month ago she was hospitalized and had surgery. Her physician told her that because she had not received care earlier, her condition was nearly fatal.

After you hear from Kim, you will hear from Duane Anger. Duane comes from Shelby Township and is a direct victim of the recession that I have cited with respect to some of the news stories even today.

For 17 years he was employed at Hoover Tool and Die in Warren, MI. Three months ago, because of the pressures of foreign competition and rising health care costs for the company, Hoover closed.

As he seeks employment, he must pay almost $400 a month to continue his family's health insurance benefits. Duane will discuss how the high costs make health care unaffordable for the American worker, and about the need to assist those who are, we hope, temporarily unemployed.

And then finally, in this first group you will hearing from Shirley Pant, who comes from Wyoming, Michigan on the western side of the State.

Shirley is 60 years old, and she has had breast cancer. She works part-time in a bakery that does not provide health insurance for its employees. Her surgery and treatments have left her with thousands of dollars of unpaid medical bills, and she cannot purchase private health insurance for any future medical needs because of her past medical history.

I just want to say again, Shirley is going to be accompanied by her daughter, Sherry Swanson, and it was Sherry that first contacted our office.

Again, if this problem has not hit you or someone in your direct family, imagine living in America today and being told, sorry, you are uninsurable. You are just out of luck. There is no place in our system for you. Imagine a country in 1991 saying that to millions and millions and millions of its people. It does not have to be that way, and we intend to change it.

Kim, why do we not start with you? I am delighted that you are here. Just pull that microphone right up.

Ms. CAMERON. All right. Thank you.

Senator RIEGLE. Get it right and close. I want everybody to hear you throughout the room.

Ms. CAMERON. All right. Thank you.

STATEMENT OF KIM CAMERON, LAPEER, MI

Ms. CAMERON. My name is Kim Cameron, and I am 26 years old. I have had Crohn's disease for 5 years. As some of you may know, another young woman with Crohn's disease testified before Senator Riegle in June 1989. Cheryl Eikler died 6 months after that testimony.

When I read about her story in Senator Riegle's Health America bill, I knew that I had to call Senator Riegle about my story. I contacted his office in July of this year and told him that I was exactly like Cheryl Eikler, and that is how I come to be before you today. Help came too late for Cheryl, and I do not want to let that happen to me.

Five years ago, I began having symptoms of Crohn's. At the time, however, I was diagnosed with colitis. Colitis is similar to Crohn's, but it only affects the colon, whereas Crohn's affects the entire digestive tract.

During this time, I had insurance through an employer group plan. However, due to cancer from another group member, the insurance company told the group that our premiums would have to be raised, because we were now at a higher risk. The members of the group figured that they could get better insurance at a lower cost privately and the group dropped the plan.

Immediately, I went to the same company that we had been covered by for 3 years and they denied me coverage. I was told that now I had become too much of a risk. Since that time, I have been uninsured.

I went to every insurance company and every HMO for coverage, and I was denied coverage at each one due to my illness. I went to Blue Cross as my last chance, and I was told that they would cover me for $167 a month, a $2,000 deductible, 6-month waiting period, no prescription coverage, and 80/20 payment plan. There is no way that I could afford that.

People are charged outrageous amounts because they are sick, and that is not right, and it is unfair. People talk about preventive care. If you know that you have a disease, then preventive care is easy. No one is going to cover you at all.

Someone who appears healthy can be covered; they could have a worse disease pop up tomorrow. All I can say is that once you get coverage, hold onto it. Last fall, after my doctor determined that I had Crohn's, not colitis, I was supposed to see him every 2 to 3 weeks. I did not go. I did not have any way to pay.

In December, I had to leave my job because I was so sick, and I have been unemployed since then. I moved to Indiana to look for work, and I found that no one would hire me because as soon as they found out I had Crohn's, that was it.

I developed blockage in my small intestine, and every meal that I ate came back up. I was getting weaker and weaker. And in March, my mom was scheduled for back surgery. I wanted to come back to Michigan to be with her. I was too sick to drive up here; my aunt had to bring me. My mom insisted that I go to the doctor, said they would pay for my appointment and take care of it.

When my doctor saw me, he told me to meet him in emergency. I told him I could not pay it, and he said his fees did not matter, he had to get me well. I lost 60 pounds in 4 months. I was really sick.

At this time, the doctor put me on steroids, pumped me full of nutrition, and I literally had feet—not inches—of intestinal tract that was inflamed. The steroids helped, but this summer, some of the damaged area had to be removed. My doctor told me in July that if I did not get myself admitted and operated on, I would have a month. That was it. He gave me a month. If I had been medicated before, I would not have gotten that bad. But I could not pay for it. And that is what makes me so angry about the system.

Three weeks ago, I got out of the hospital after a 17 days stay, where surgeons removed part of my colon, 8 inches of my small intestine, my appendix, and my gallbladder. I cannot pay for this care.

Just last Wednesday I went to my doctor for a follow-up visit from the surgery and I was told that I could not see him until I settled my bill. Well, I explained that I could not pay and they would not let me see my doctor.

Finally, I lied and told them that I would pay my bill after my visit. And after the visit they stopped me and insisted that I paid. Well, I used the last $10 on my credit card. That is all I could do. The last $10 on my credit card, and paid something on my bill. They cannot say I did not pay anything. I paid on my bill. You cannot imagine how awful it felt to be treated like that. When the hospital tells me that I have to pay, I tell them I cannot pay until I can work, and I cannot work until I get well. Get me well, and I can pay. I asked the hospital to give me a job, they could garnish my wages. But they will not do that.

It drives me crazy that I cannot work. I started working part-time at age 14 baby-sitting every weekend, and full-time by the time I was 17. And now, no one will help me. I have tried to help myself, but that only goes so far.

My dad could get me on his Blue Cross through GM, but there are waiting periods. And then he would have to take full financial responsibility for me, including all my back bills, and $100 a week premium. I cannot let him do that.

My parents are not wealthy people, and I will not let them lose what they have worked for so many years. I mean, they are getting older. But I have a lifetime of wages to garnish ahead of me.

I have applied for Medicaid twice, and the first time I was denied because I made too much money. I make $4 an hour. The second time, I was denied because I was over 21, under 65, not blind, not pregnant, and I had no dependents. I have also been denied Social Security disability.

Senator Riegle's bill would help me. I could get the coverage I need. Crohn's is a treatable disease, if you can pay for it. I support Health America.

Senator, you have asked the people of Michigan for their comments about the bill. I particularly like the provision in your bill that requires insurers to cover all people, regardless of whether or not they have a pre-existing condition.

Also, the improved rating structure would spread the risk over more people that would make premiums more affordable to me. I see that the bill covers pregnant women and children first. I agree that that is important. But there is coverage out there for them. As they said, if I was pregnant, I could be covered.

Now, that, to me, I think, the people who are now ill and have no coverage are pretty important and right up there. It is not just me. There are people with cancer out there, and heart disease, that need it, too.

I am not asking for something that I do not deserve. Every American deserves quality health care, and Health America will see that they get it. Thank you for allowing me to testify today.

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

Senator RIEGLE. Thank you. I think we ought to give Kim a round of applause. [Applause.]

It is not easy to talk about these things and to share them in such a public way, and to do so, so well. I thank you for that. You are helping a lot of people in addition to yourself, and I thank you for that.

I think what Kim has not said, she delivered those remarks so beautifully that it is hard to imagine the terrible pain, and the fear, and the terrible anxiety that she has had to live with through all of this time, and is living with today, and will live with tomorrow. And how do we factor all of that into the equation? It ought to count for something. I think it ought to count for a lot.

Duane, thank you for coming today. Let us hear from you.

Mr. ANGER. Good morning.

Senator RIEGLE. Pull that mike right up close, if you can. I want to make sure everybody can hear you throughout the room.

Mr. ANGER. All right.

STATEMENT OF DUANE ANGER, SHELBY TOWNSHIP, MI

Mr. ANGER. My name is Duane Anger, and I am from Shelby Township, MI. My wife, Valerie, and I have three children; two twin daughters, 14, and a 6-year-old daughter. I want to thank Senator Riegle for the opportunity to testify to the health insurance concerns and problems of those who are unemployed.

I worked at Hoover Tool and Die for 17 years. Hoover manufactured tools and dies used in the automotive industry. I started there as an apprentice, moved on to become a journeyman machinery builder and electrician. I was eventually in charge of all repairs of precision equipment and building maintenance. It was a good job over the years.

I was also actively involved with the UAW Local Union 155, serving as apprentice coordinator, chief steward, and contract negotiator.

When I first started at Hoover, we had over 100 employees. During the 1970's, we ran into some bad times, and that was the

beginning of some stiff foreign competition. As a result, company employment declined. The 1980's were worse than what the end of the 1970's were. In January, we had numerous lay-offs than the 1980's. In January 1990, we were down to 40 employees. In January 1991, we were down to 12 employees.

Our profits fell sharply, due not only to the recession, but also to the cost of health insurance and other insurances.

At Hoover, we had a good health insurance plan. And the cost of that plan cut into the company profits sharply. We liked the plan because the coverage was good. But it was very costly to the company.

Ironically, as our number of employees decreased, our health insurance premiums kept going up. In fact, other than the recession itself, company insurance costs was one of the company's major financial downfalls.

When you have 40 employees trying to make a profit to cover those 40 employees, plus office personnel, plus 50 to 60 retirees, it was almost impossible. The cost was astronomical for the insurance.

We tried offering HMO's and started out at a relatively low premium when they first became available. But over time, they have jumped as high as premium for Blue Cross, and, in one instance, the premiums were higher.

I was laid off on May 7 of this year. I was the last employee to be laid off of Hoover Tool and Die. The company has closed and is not expected to reopen. In my particular case as a union member, we had negotiated our health insurance coverage to continue for 3 months from the day we were laid off.

As long as the corporation keeps their Blue Cross plan in effect, I am allowed, under the COBRA law, to pay my insurance for the next 18 months at the premium the company was paying. After the 18 months, I will have to pay over $500 per month to keep the same coverage that I had while I was working at Hoover.

I also have to think about my unemployment insurance. Once the 26 weeks of unemployment insurance is used—and believe me, it goes quickly in a recession such as ours—I will need to think about the health care costs more closely, house payments, getting food on the table, and all these other daily and necessary expenses.

I am well aware that there are many uninsured and under-insured people right now who face more dire circumstances than me or some of my colleagues, but that does not make the fear of losing health insurance and not being able to afford coverage any less real for us.

Just the other day, I hesitated when my wife said she thought maybe we should take our daughter to the doctor. She had a temperature, and she has a chronic problem with her ears.

And then I became angry at myself because I hesitated there for a minute to send her to the doctor, because I had not paid my insurance premium as of yet, and I was afraid of what the cost would be. And I was ashamed of myself that I even had to think about it for a second.

Just the other day I got my hair cut and I was talking about what I was going to be doing here today to the gentleman that was

cutting my hair. And he said to me, well, I do not have health insurance.

Now, he has been cutting hair for 19 years and he had to drop the insurance coverage for him, and his children, and his wife because he could not afford it anymore. The premiums just had gone up, and up, and up on him.

Every day he wakes up for the last 3 years, he said the first thing that is on his mind is something going to happen to one of us today where I am going to have to go into the hospital, or one of my children, and he knows it would break him, the cost.

I have got one fellow worker who was making only $7 an hour. He was a laborer with a family of four. He is now unemployed. It is out of unemployment insurance. He cannot find a job anywhere, and believe me, he has looked every day of the week.

It is hard for him to take a $7 to $8 an hour job and still pay for his home, for food for the children, for some type of vehicle to look for a job or get work at $372 a month. That is what it would cost him for his family.

So, what he is thinking about doing is going on welfare just so that he can—which to him is a last resort—so that he can cover his children. Like others who are concerned about the high cost of health care insurance, unemployed people are afraid to let their insurance collapse.

But for some, it is not a choice: they just cannot afford it. After high school, I attended college for 2 years, and in the 19 years since, the most humiliating experience I ever had was going and signing up for unemployment. I had never been laid off before, and I got the feeling that people, as they see me walk into the unemployment office, thought, oh, there is a guy that is lazy or did not want a job. But this is not true whatsoever.

And, in fact, a lot of us that have insurance or have had it, we have a tendency to overlook the situation of people that do not have insurance. We tend to go on with our lives and we feel bad for them, but we really do not do anything about it.

And most of the people that I work with are all out there looking for jobs. A lot of them are applying for jobs that do not pertain to their skills just so that they can make enough money to pay their insurance.

Keeping health insurance going is probably the number one concern of most of the employees that I have talked to are represented at Hoover Tool and Die—more of a concern than even making the house payment, especially for those with young children.

Since being laid off, I have kept in close contact with the fellows I worked with. And if I hear of anything that matches their skills, I let them know. The trouble is, a lot of our employees were journeymen skilled tradesmen. And they are having a hard time in a recession finding a job—any kind of a job. A lot of them that were making $19 an hour are looking for jobs for $10, $11 an hour.

And there is a tendency for companies not to hire these people because of what their previous wages were. And what this does is a lot of companies that we have talked to is they are hiring part-time employees to keep away from paying coverage of hospitalization, or offering medical insurance.

I understand there are almost 40 million people without health insurance. Unless something is done, that figure is going to get a lot higher. When negotiating contracts, a lot of the companies would try to lower their health care costs. Sometimes companies will choose to hire part-time than full-time so that they do not have to pay those health benefits. It just is not right.

Nobody wants to be unemployed. When you lose your job unexpectedly, like we did at Hoover, it is quite a shock. It really brings you back to reality. There is no place for a lot of people to turn. If they cannot get a job right away, they have to somehow find a means to get their insurance, or they just have to let it go. Because of the recession, in part, I lost my job. I am collecting unemployment insurance and hope to become employed before it runs out.

As a union member, I am thankful that I can continue my health benefits for my family and I, even though I am not sure how long we can afford it at the high cost of the premiums. And I am willing to do whatever it takes to find work.

While my job search continues, I do not want the additional burden of losing my health care insurance or not being able to provide health protection for my family.

I am glad, Senator Riegle, that your bill contains provisions that would allow the unemployed access to health insurance coverage based on their ability to pay. This is an important provision that will address a very real and growing problem.

The cost containment aspects of the bill will also make health care more affordable for me and for companies like my previous employer. I think we have to have some type of bill like Health America.

It is sad to know that while we are floating billions of dollars to other countries, that almost 40 million of our own live without health insurance.

It is really a failing when you think that we can put a man on the moon, or we can pay athletes millions of dollars to play a game, but we cannot find a means to provide insurance for every single American.

I am just an average American who has worked hard to provide a decent life for my family. I do not want my temporary employment crisis to put my family's health in jeopardy. If you were me—and anyone could be in my situation—I know you would want the same for your family, too. Thank you.

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

Senator RIEGLE. Thank you, Duane.

[Applause.]

You know, I am struck by several points that Duane makes, but I will just comment on one. That is, you are still drawing unemployment compensation because you have not yet drawn your full 26 weeks?

Mr. ANGER. Right.

Senator RIEGLE. We have got an estimated 170,000 people in Michigan like Duane who are unemployed, but who have exhausted or will shortly exhaust their 26 weeks and who have not found work, and therefore, need to have extended unemployment benefits; which is what we have done in all previous recessions. We just passed a piece of legislation to provide extended unemployment

benefits because of how long this recession has gone on that would reach those 170,000 people in Michigan. It turns out there is $8 billion in that extended unemployment benefits compensation fund that has been collected over the years for precisely this kind of a problem.

We have passed the bill, but, as I think many of you would know from reading the newspapers, it requires a decision by the President to implement it, and he has decided not to do it. That is the wrong decision, because the money is there for precisely this purpose.

For example, it would help those workers continue to meet the COBRA costs of maintaining health insurance until they can find work. That would be one thing that could be accomplished by that extension of unemployment benefits. Our State, because of the higher unemployment, would be eligible for another 20 weeks.

In addition, if you think that just relates to somebody else and not yourself, if you were in that situation, it would put $570 million into the Michigan economy. Every dollar of that that is spent by you for a haircut, or whatever, helps somebody else make a living. That money moves around and it helps the whole economy. It lifts the whole economy and keeps somebody else from being put out of work.

We are not here to discuss that issue today, although that issue is within the jurisdiction of this committee—namely, the Senate Finance Committee. I wrote that bill that was just passed of which the President is not implementing. We are going to bring it back again when we go back into session next week and try to find a means to make it law over his objection.

I appreciate very much what you have said, and it is very difficult to come and talk about these things if you are talking about your own circumstances. I am very proud of you for doing it, and I thank you for your being here to share those facts and to try to help people.

Shirley, let me now call on you and I am going to invite you to make your comments.

STATEMENT OF SHIRLEY PANT, WYOMING, MI, ACCOMPANIED BY SHERRI SWANSON

Mrs. PANT. Good morning. My name is Shirley Pant. Thank you, Senator Riegle.

[Whereupon, Mrs. Pant's daughter, Sherri Swanson, read the prepared statement of Mrs. Pant.]

Mrs. SWANSON. Thank you, Senator Riegle, for the opportunity to be able to tell you about the struggles and fears that I have experienced over the past couple of years after being diagnosed with breast cancer.

She is 60 years old, she is uninsured, and has been most of her life. In May of 1990, she detected a lump in her breast. At the probing of her daughters, she went to see the doctor and ran through a battery of tests.

It was soon determined that she had to have surgery. I had this feeling of dread that the doctors would find cancer, and they did. My doctor knew I was uninsured, but was kind enough to say that

first priority was to get me well. He found me the least costly cancer doctor to do the mastectomy. All the while, my mind was filled with thoughts of how I was going to pay this. As I mentioned, I am uninsured. I do work, though, and have all my life. I single-handedly raised four children and own my home. I work for a bakery. It is a small business with six employees. The owners cannot afford to co-buy health benefits. I make $4.75 an hour. I work part-time, mostly third shift.

I take advantage of extra hours when I can, but Senator, what I earn cannot begin to cover the individual insurance premium, or the $10,000 in medical expenses I have been trying to pay.

My life was given back to me, and now I live with the mental stress of trying to pay my bills. After the surgery, I was not able to work for 3 months. Also, I had take chemo treatments every 2 weeks for 6 months. Every treatment costs me about $700, but what choice do I have?

What really makes me mad is the bill collectors. I hardly got back home from surgery and they started calling me and asking me how I intended to pay. I told them I did not know, but said that the would get the money slowly.

They had the nerve to tell me that I should not have had the procedure done if I could not pay them. They even suggested to get another job. Let me tell you that a woman of 60 years old, there are not that many jobs; especially jobs that pay more than what I am making.

One bill I promised to pay $50 per month. They said that was too little, and now they have garnished my wages for $75 a month. Some weeks I do not even know how I am going to put food on my table. Thank goodness for my family and my friends of my church.

I have shopped around for health insurance policies in the past. All were way out of the price range for my monthly premiums, of $375 or more. This is at least three-quarters of my monthly income.

Now, with a history of cancer, I am considered uninsurable. I do have a little health policy if something would happen where I had to be hospitalized; it would pay $50 each day.

I had my breast surgery as an out-patient, so this policy did not cover it.

I also tried to get public assistance. I do not qualify for disability or SSI. I have to wait 5 years to get Medicare. My income has lowered, but I have been still turned down for Medicaid. I was told that I had to sign my home over in order to get financial help. To this I say, no way, I have worked too hard. Since then, I have learned from your staff that my home does not count in being eligible for Medicaid. Also, many people get turned down the first time. I am now working with your office to see if there is help. It has been a year since the cancer.

In February, I was given a clean bill of health, with instructions to get a mammogram in July. I never kept the appointment. I have enough bills to pay without paying another $95 for a test.

My doctor has arranged for me to get my prescriptions at no charge. He also says that I have to have tests in October. Since I doubt much will have changed, I will not be able to go then, either.

Senator, I will be willing to pay for affordable price for health insurance if a plan were available. With my health history, my

daughters are also at risk for breast cancer. I just hope that a solution to the uninsured will be found. I do not want them or anyone else having to face the same problems some day that I have. Thank you.

[The prepared statement of Shirley Pant appears in the appendix.]

Senator RIEGLE. Thank you, Shirley. [Applause.]

Let me thank you, and let me thank your daughter for coming and sharing that. I know that these are not easy things to talk about, and it is very important to everybody in this room who is hearing these case histories, and we could have hundreds of people here from different situations.

You have heard from three different kinds of situations now. We could fill this room. We could have people in here testifying one after the other for the next 5 months on situations similar to this.

And the issue is, what are we going to do about it? Because we have to act on this problem, in my view, and I think in our society. Those of us fortunate enough to have health insurance coverage today may have to realize we may have it today, we may not have it tomorrow.

If you take Duane's case, probably the top worker in that plant was the last one laid off; 17 years of experience, probably does his work as well as anybody in the country that you could find to do it. He cannot find work right now, despite that outstanding work record and having been that valuable employee, and the fact that he is a younger man and presumably has a good, long work history ahead of him.

And I think it is entirely possible, given the perverse nature of a lot of things that are going on in our economy today that if the ball takes the wrong bounce, instead of sitting in the seat you are sitting in right now, you might be sitting in his seat, or in Kim's seat, or in Shirley's seat, or another seat that is comparable to that.

Particularly if a major illness crops up and your job situation changes and you become a kind of leper within our system, from an insurance point of view, where you become "non-insurable," no one wants you. Or they will offer you an insurance policy that you cannot afford and that does not give you the coverage you need, so that the answer you get is no answer.

And that situation is not that far away from an increasing number of people in our society. I say that because this is not somebody else's problem. This is everybody's problem. The cost of the uncompensated care is making its way back through the system.

For example, this $350 million worth of uncompensated hospital care in just Michigan alone last year, has to get paid for some way. And so it gets cost-shifted back through the system. It gets built into the insurance premiums of those who have insurance; it gets built into the reimbursement rates and the welfare payments that the State and Federal Government end up paying.

Those costs go somewhere and have to be met in one fashion or another. Yet that is really the least of it. The far greater part of it is that people need what they are not getting. Care that they are not getting is threatening their lives; in some cases, taking their lives.

I mentioned Cheryl Eichler before when she testified before our committee, and her sister, Luann Nunnally is here, and her husband, Bob. I would just like you stand up, if you would. I would like to just acknowledge your presence. [Applause.]

I think Kim is out doing an interview right now, but Cheryl, when she came to testify at our hearing some time 2 years ago plus, by the time we had arranged the hearing, she was in the hospital, and she checked herself out of the hospital to come and testify.

So, for her and for everybody else that it in this situation, this is a job that we have to get done. Part of the necessity of us today in this room is to understand our own responsibility to move things along to get some new answers in place that can meet these circumstances.

And we can do that; it is fully within our capacity to do it. We have to decide to do it. We have to decide it is important. We did decide it was important to go to the moon, and we spent a lot of money doing it. And we did it spectacularly.

We sent people to the moon almost 20 years ago. Landed on the moon, came back; we do all kinds of great things. It cost a lot of money and the skills and the know-how that it takes to do that is no more complex—I mean, this problem is no more complex than that one, and we can solve this problem just as readily—in fact, more readily—than we can solve that one if we just decide to do it.

Part of what we have to do today, individually, is make some decisions in that area as to whether or not this is something that we want to get done and get done now in this timeframe. I am convinced we can get this done within the next year if we make a major, public, push. I am going to do two things now. I am going to just take a momentary break to give—well, I guess I am not going to do that. [Laughter.]

I want to go to our business panel, and we are going to shift perspective. I want to say to our business witnesses today that we appreciate your participation and involvement in the hearing very much.

It is very important that we find a way to make insurance coverage workable and affordable for businesses that are striving mightily to provide health insurance for their workers.

I have cited the example here with respect to just one large company in our State, but we have a series of companies here today. So, I am going to introduce our three business witnesses. I will introduce each one now and then call them in order.

Pearl Lipner is the co-owner of a company called Imagine Express based in Southfield, MI. This company provides health insurance for its employees, but has found that high premiums and rising costs may make continuing this benefit just financially impossible for this company. Ms. Lipner will discuss the impact of Health America on small businesses such as hers.

Next, we will hear from Mr. Howard Johnson, who is director of personnel services at Herman Miller, a very well-known and highly respected furniture company in Zeeland, MI. Herman Miller offers probably one of the most progressive benefit plans for its employees.

Over the past years, they have experienced sharply rising health care costs, causing the company to require higher employee contributions, and, in turn, to have to scale back the benefits that they offer.

Mr. Johnson will discuss and testify on how cost containment provisions in our legislation here would have an impact and generally he will talk about how rising costs are affecting larger scale businesses like Herman Miller.

He will be accompanied by Mr. Robert Johnston, who is the director of corporate affairs for Herman Miller.

Finally, we will hear from John Bond, who is the business manager and the financial secretary of Local 948, which is the International Brotherhood of Electrical Workers in Flint. Mr. Bond will discuss the problems that workers are facing due to the rising health care costs. So, he is going to give the perspective of what is going on in the business community, but from the point of view of the work force in the company, as opposed to those that are managing the company. So, he will focus his comments on the cost containment provisions in Health America from his vantage point.

So, Pearl, we are delighted to start with you, and we would welcome your comments at this time.

STATEMENT OF PEARL LIPNER, CO-OWNER, IMAGE EXPRESS, SOUTHFIELD, MI

Ms. LIPNER. Thank you, Senator. I would like to thank you and the committee for asking me to be a part of this hearing and the process of exploring Health America.

My company is Image Express, and we edit television commercials. We are a very small cog in a very large industry. However, like many other niche-inhabiting companies, the work that we do is quite esoteric and requires formidable skills.

It is, therefore, necessary for us to pay high wages and offer a substantial benefit package to our employees. These number 21 full-time permanent; and, because our work is season, up to 10 more temporary who are employed as part-time and/or independent contractors for several months a year.

Annual salaries range from $16,000 to over $100,000 and totalled $1.2 million in 1990. Our monthly health care premiums are $146 for single coverage, and $458 for an employee with dependents.

This includes a $500 deductible, with an 80/20 co-pay on the next $2,000. Not counting the health-care portion of FICA, executive life and disability premiums, or the administrative expenses of our Section 125 flexible benefit package, our at-risk cost for employee insurance was $100,000 for last year.

As a percentage of salary, these costs range from 23 percent for lesser compensated employees, to 6 percent for the most highly paid, with an average of 8.3 percent overall.

We started this business in October, 1978, and have had continuous coverage since the first year. It has taken many and varied forms and has never, in nearly 13 years, been easy to deal with. There have been times that I could track a loss on our balance sheet directly to premium payments.

In a closely held corporation, this decrease in owner equity can certainly give one pause to reflect on the order of magnitude of responsibility to one's employees, particularly for a benefit that is available as a private-pay purchase.

Certainly as the economy, in general, continues to droop, and advertising, in particular, tightens its belt, the cost-cutting imperatives could seem to outweigh the previous sacrosanct package offered by my company. In the last 3 years, we have had our premiums costs raised by 42 percent, 13 percent, and 6 percent, which is a cumulative increase of almost 71 percent. And, we have been told by our agent that we have been lucky, because these increases have been lower than those of many businesses in our market.

Needless to say, since inflation has done nothing to deflect this leap, this erosion of our margin makes quite a difference to our bottom line. For as vendors to the automotive industry, we have not been able to raise our pricing the reflect this increase.

The average age of our staff is 32, and we have suffered only one catastrophic illness, which lasted 6 days, in almost 13 years. This is not a high-risk group, nor is there very much abuse of benefits.

Given those factors and the unhealthy state of the economy, the subject of insurance becomes more sensitive each time we have to determine budget. Although it has always been important to the company to provide total medical protection—and we certainly want to maintain the standard we have set—it would be fiscally irresponsible to ignore the obvious.

In the event of the need for a budget cut, the deletion of this coverage could, if necessary, mean the preservation of five jobs. That is almost 25 percent of our current work force.

If faced with a choice of insurance benefits or a job, you cannot ask people to draw straws to see who is going to leave for the good of their co-workers. Duane's testimony was a graphic example.

With that in mind, I would like to turn my remarks to the proposed Health America bill. It has always been the case that the philosophy of Image Express leaned toward the welfare of its workers. The corporate policy was to try to eliminate any distractions to an employee's productivity caused by concerns that we could lessen.

Complete health and medical coverage is one of the ways of accomplishing that goal. It is much easier to devote your attention to your job if you know your doctor bills, or those of your family, are covered and you do not have to worry about where the money will come to pay for them.

On the face of it, this bill could eliminate that concern for millions of people and enable greater participation in the daily work effort of this country. Since my portfolio is small business, that is the only portion of this bill that I will be addressing.

I do wear several hats in this situation. One as a business owner in a much more cost-conscious economy; as the administrator of a qualified flexible benefit plan normally offered by much larger companies; as a believer in basic health services for all people; and, as a small business association board member that has seen what a proliferation of new laws, regulations, and government divisiveness have done over the past 8 to 10 years to discourage privately held business owners from having as much as faith in government pro-

grams as might be appropriate. Therefore, my thoughts may sometimes be at odds with each other, and I hope that you will bear with me.

There are some pleasant surprises in Health America. To whit, individual responsibility for some of the costs; preventative health benefits which are often not even covered by the most expensive private policies; recognizing the need for health care for low-income, non-aid dependent employees and their families; pre-existing condition limitations on coverage; an improved delivery system; a reduction of unnecessary or ineffective care; the elimination of unnecessary administrative costs; and particularly a standardization of claim forms and the use of high tech systems to minimize paper work; small business insurance reform; the development of cost and quality data on individual providers, as long as it is more than just a computer game played by a bureaucratic agency used to self-perpetuate a body of redundant information; improved tax treatment for the self-employed is long over due.

One of the most encouraging aspects of this proposal is the provision for tort reform and investigation of the malpractice problem in this country. It is significant that this issue is part of a package that promotes primary care services in under-served areas.

One of the main reasons that we have seen a lessening of services in the seventh largest city in the U.S. is the astronomical cost of malpractice insurance in Wayne County. It has become almost virtually impossible for an independent doctor to practice medicine in the city of Detroit. This is a travesty.

In recognizing that there will be revisions to this bill, I would hope that the following concerns will receive thorough consideration.

"States will be given the option to require those employers who elect to make a contribution to the public program to collect the employee's portion of the premium. In the absence of this requirement, employers will be allowed to voluntarily collect premiums on behalf of employees."

I do not know which part of this statement I resent more. In essence, we again become the collecting agent for a taxing authority. Right now it is mandated that an employer, of any size, has the responsibility of collecting and distributing to the appropriate funds FICA, Federal, State, and any other local income tax that an employee has an obligation to pay.

There is nothing voluntary about the deduction collection and/or distribution of any of the aforesaid monies by an employer. And to state that we would ". . . be allowed to voluntary collect . . ." really pushes the point. [Laughter.]

In California, where my company has an office, we are already responsible to five different taxing authorities with five different reporting procedures, at five different points in time. This plan would add a sixth deduction to keep track of and be accountable for. Besides putting the employer in the role of being an unpaid revenue agent, it creates an animosity with the employee who sees me as the reason that their check does not reflect the wage that they believe they are being paid.

I understand the savings to government that this service provides. This might be the time, however, to ponder what consideration these agencies might offer in return.

By setting 17½ hours as an indication of full-time employment, I fear that students will no longer be able to find after-school jobs because it will be too much of a problem to go through the paperwork necessary to certify their exemption because of eligibility under a parent's plan.

It also makes a number of employers responsible for workers that have previously been covered by Medicaid under some type of government or industry-sponsored training program. This becomes unfair to the employer without added incentives to hire these people.

Although I stated I would only be addressing the business portion of this plan, I cannot help but comment on some of the aspects of the public plan.

Since this is a Federal-State program, created to extend basic medical services to all people equally, it seems strange that there is a State's Rights provision to determine optional services.

Does this mean that some States will be able to continue to exclude certain legal medical services available in other States? Does it mean that some States will be able to triage care, as is now the case, that does not fall under the basic plan?

"During the first 5 years after enactment, small businesses that have not provided coverage to their employees during the year prior to enactment of the legislation will be allowed to buy insurance . . . at a lower cost."

I currently spend $100,000 a year more than my closest competitor by offering a good health care package. This is my decision to make as a business owner.

However, this provision "unevens the playing field" by government intervention, and has my taxes paying for my competition's ability to take into account this cost advantage while bidding for a job against me.

To end my litany against specific provisions of this bill, I would like to state my concern for the use of a $53,000 figure to establish a "high profit firm." I believe that although the intention is valiant, the criteria used falls short of the mark needed to give relief to the targeted businesses.

I have yet to address the main concern of small business with this bill. It is mandated benefits. The reality is that small business abhors mandated benefits of any kind, even if they seem to solve basic issues. I am sure that you will receive other testimony that can better address this issue.

We fall behind so many other countries in the treatment of our citizens, that the least we can do is bring our vast medical expertise to all of the people who need it, without reservation or discrimination, or at the whim of some local body only concerned with reelection based on budget control to the detriment of a non-aligned constituency. Thank you.

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

Senator RIEGLE. Thank you very much.

[Applause.]

Let me thank you for such a helpful and constructive set of comments. I thank you for the time and effort involved. I think what you have done here, quite brilliantly, is to juxtapose a number of the issues and difficulties that are faced in trying to reconcile a series of objectives that cut against each other in some ways.

This is one of the reasons—and a very useful point you make—why a lot of people walk up to the water's edge on this issue and say, "well, you know, this really needs to be fixed, but it is just a little too tough."

Because there is no easy way to do this part of it, or do another part of it, and there is a cutting and fitting process that is involved in any kind of a re-engineering system that a broad coverage system is difficult. It is like hand-tailoring.

There is no way it can be done short of exactly the kind of process we are going through here today. Today is part of the hand-tailoring. It is to gather expert comment for evaluation purposes.

It is one of the reasons we are taking the committee record word for word, so that we can weigh and evaluate each point that is made and find an answer, some balance, with all of the other considerations that have to be weighed at the same time, to get the right blend, the right package.

Even in saying that, it makes it sound as if there is a perfect answer and, of course, there is not. It is the nature of democracy or anything we want to talk about that, in doing this we get as close to the best answer that we can find, and things will change.

There will be things that will need to be adjusted on the margins here or there. I know everyone here, on this panel, understands that.

So, I am, in a sense, re-stating an obvious point. But it is important to make, because we are not embarked on an exercise in absolutes. What we have got is a system that is way out of kilter and I am afraid, if it goes on much longer, is likely to help sink a company exactly likes yours.

The trend lines you are on, without a radical change in internal procedure may be the thing that shrinks your business. You are weighing this trade-off right now. Reduce the benefits versus five jobs.

I take your comments in the most constructive way, and you have made a number of important points. They will be ones that I take into account and bring to the attention of my colleagues as we work on this. There are some concerns that you have that we have already answered.

I am not going to take the time right now to go through those in terms of the fact that we do not, in fact, impose a mandate, and we do have the procedures to make sure that you do not get end plate State to State or that kind of a problem.

But I think what I should do now is probably go ahead and call on Mr. Johnson so we can also get the perspective of a larger firm coping with these very same issues.

Mr. Johnson, we are delighted to have you and would like to hear from you at this time.

STATEMENT OF HOWARD JOHNSON, DIRECTOR OF PERSONNEL SERVICES, HERMAN MILLER, INC., ZEELAND, MI

Mr. JOHNSON. Thank you, Senator. We were asked to testify at this meeting, and as we looked at the legislation, we felt there were both pros and cons to it. We were encouraged to identify, what we saw was good in the bill, and where we saw concerns. So, in going through my statement, realize that I have both sides that I would like to present.

Herman Miller is an international organization with some 6,000 employees. It is committed to providing coverage for the employees and their dependents. It has been doing that for over 40 years.

We have many part-time employees and we make coverage available to them; for those employees that are scheduled to work 20 hours or more per week.

We are committed to providing insurance protection for our retirees and their dependents. We require that they have at least 10 years of full-time service with the company.

We also cover the extended family, providing pregnancy coverage for single, dependent children of employees.

Continuing health care coverage is not only given through COBRA, but we also offer continuing coverage to surviving spouses of all employees and retirees who pass away after age 55.

We also show concern for employees and members of their families who have pre-existing conditions. We provide coverage for pre-existing conditions at the time of employment. The company is——

Senator RIEGLE. May I just stop you there? If I may just say so—just to interject, that is a remarkable listing that you just heard, and there are few, if any, companies in the United States that have such a far-reaching effort to try to provide health care, in the broadest sense, to its workers and to the family members and dependents.

That is greatly to their credit, but it is so extraordinary that I did not want the moment to pass without noting it. Why do you not continue?

Mr. JOHNSON. Thank you. The company is self-insured and at-risk for each employee and dependent for the first $200,000 expense in a given year, and there is a $1 million lifetime limit coverage per person. You might wonder how many employees or dependents have that kind of an expense in a year. Typically, there are not many, but this past year we had five employees or dependents that had expenses of over $200,000.

The average annual gross cost per employee is about $3,500 for medical and dental coverage. The cost is rising at the rate of over 10 percent per year.

The rising cost is a major concern to the company. Constantly rising costs are eroding the company's profitability margin and limits its ability to grant wage increases and benefit improvements.

As a result, the company has had to shift more cost to the employees and has emphasized managed care through HMO's. The company has also added a preferred provider network. Currently, over 50 percent of Herman Miller employees are enrolled in HMO's.

We support and encourage the efforts that are being made by the Federal Government to provide comprehensive health care reform, including cost containment and universal access to health care.

With respect to the specific health plan, AmeriCare, we are supportive of many concepts in the proposed bill. These include: broadening access to health care coverage to many more Americans, providing that access by way of the employers, the basic benefit package, and cost-sharing concept; reducing cost-shifting to private sector payors; emphasizing managed care and providing coverage to part-time employees.

We personally believe that the 20 hours eligibility requirement is a much more manageable number than 17 and a half. We saw 17 and a half in Section 89, and thought that was just a really odd number to work with; 20, to us, makes much more sense.

We also support the concept of addressing medical malpractice liability reform; establishing standardized claims and billing forms; pre-emption of State-mandated benefit laws; expanded use of practice guidelines and expanded outcomes, research and technology assessment; providing coverage for pre-existing medical conditions; restructuring and expanding the publicly funded insurance for lower income persons.

There are a few concerns that we have. First of all, the size and the source of public funding required to implement and operate the plan. In a couple of instances, it is identifying that there is going to be subsidy for low-income workers, as well as the public programs being financed by the State and Federal contributions.

It is important for companies such as ours to know what this plan will require in new taxes.

We also think of the employees. We are thinking of the FICA taxes and the fact that self-employed persons already pay 15 percent of their income for this tax. If it is publicly funded, what is it going to do to those rates? I think we need to see the final design of the plan before we can endorse the financing plan.

The next point is the possibility of special interest medical groups influencing the design of the plan to insert coverage which goes beyond basic health care. We have seen that happen in a couple of States that have mandated benefits.

For example, there is one that required in vitro fertilization coverage. This requirement is just way beyond basic health care. We are concerned that as this plan is designed, that special interest groups do not enter the picture to spoil what could be a very good plan.

The possible complexity of administrative rules and paperwork which will be imposed on employers concerns us. I think that it is really important, as the design is being looked at, to think of the employer that must deal with the administrative requirements of the plan.

Another point deals with the section dealing with "two family members of employed" provision. In the plan it is identifying that parents may choose which employer plan will cover their children.

It is saying that a person would have a choice to go to the more expensive plan provided by the other employer.

In effect, that is cost-shifting, back to the person who has the better plan away from the lower coverage plan. I really think that

it may not be in the best interests of the person that is turning in a claim.

Normally with coordination of benefits, if there is a benefit paid at a lower level, it then coordinates with the second plan and the bill may be paid in full.

If, however, under the proposed plan a person chooses the company's plan which pays the most, the person may only be paid up to an 80 to 90 percent level and not be able to coordinate coverage up to the 100 percent level. I believe that this portion of the plan needs to be reviewed and possibly changed.

I suggest that, as your committee works on this bill, you have a person from industry help in the final design of the bill particulars.

Just one final point. You have talked in it about a company being able to opt out and just make a contribution to the public plan.

Senator RIEGLE. Right.

Mr. JOHNSON. And it would be a percentage of payroll. Now, if you look at the health care costs as a percentage of our payroll, it keeps going up, up, up. What may have been 7 percent became 8, 9, and now it is well over 10 percent of payroll.

If you are setting the percentage for employers that have the option to opt out, and let us say you set it at 6 percent or eight, or whatever, and leave it there, it is really meaning that as the health care cost inflation goes up faster than the payroll bills, there is more and more being shifted away from the employer to the public.

And you are thinking of competitiveness. People may well say it is cheaper for me just to pay that amount to the government as opposed to setting up the plan and administering it.

Senator RIEGLE. Right.

Mr. JOHNSON. Again, as part of design, it is really important to think those issues through before it becomes a public bill before Congress.

That really concludes my remarks, and thanks for the opportunity.

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

Senator RIEGLE. Well, thank you again. [Applause.]

Again, I want to thank you for a very constructive set of comments and the analysis that you have done, of which I have taken good notes. We have got, as I say, a transcript to refer to, as well.

These are precisely the observations and inputs we need, because the difficulty of structuring the trade-offs, and the engineering design, is extremely important. It is not going to be done by a cookie-cutter approach.

I want to make sure we have factored in everything that we can understand so we do this intelligently in every way that we can.

Mr. Bond, we are pleased to have you, and we would like to hear your point of view now.

STATEMENT OF JOHN E. BOND, BUSINESS MANAGER AND FINANCIAL SECRETARY, LOCAL 948, INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS, FLINT, MI

Mr. BOND. Good morning, Senator. Thank you for the opportunity to address the people here this morning on behalf of the International Brotherhood of Electrical Workers and myself. I am the business manager of the Electrical Workers Union in Flint. We represent about 400 people presently, and I would like to offer some comments.

I would like to address some of the many problems with health coverage in this country. Costs of proper health care in response to the Health Care America have been increasing in our industry, at least as electrical workers have over many years.

Cost containment of health care is the most important single issue facing our Nation today, and is one of the overriding issues in almost all labor negotiation today. If something is not done to control the rising cost of health care and provide the necessary treatment for those in need, I believe millions of Americans will continue to suffer. I belong to a health plan in Michigan that covers over 2,000 participants. At the present time, I am a trustee of this plan and also the chairman. We cover all the Union Electricians in the Upper Peninsula and all but those Locals in Detroit, Ann Arbor, and Saginaw areas down State.

Our problems vary because of the large geographical area that we cover, but have one common problem. That is the rising cost of health care. From the smallest town in the Upper Peninsula to Flint, the concerns of health coverage are the same. If something is not done to stop the rising costs, it will just be a matter of time that no one will have insurance, and if they do, the coverage will be so small that it will not be worth having.

In the past years the cost of our insurance has risen 41 percent for our active members, and 114 percent for retirees. While these costs have gone up, our benefits have remained the same.

This means that more of our dollars are going toward health coverage and less for educating our children, providing needed things for our families. Every time the cost of medical bills go up, there are thousands of parents that are unable to buy something that is needed for their family.

Six months ago, our health plan was told by our actuary that we were going broke. He told us that, if we did not make some major changes within the next 2 years, we would be out of business. We decided to add thirty cents per hour per member to offset the difference.

Three months ago we were told that that was not enough and more changes had to occur. It was recommended by a committee of trustees that we have all self payers pay more into the plan to keep their insurance. This recommendation was approved. Yet still today, there are concerns that we may have to either add more money or reduce benefits. These are things that are not only happening to our plan, but happening all over Michigan.

The retirees in Michigan may be the ones dramatically impacted the most by health care. They are caught in a catch 22. They are the ones who can least afford to pay for it.

The retirees in our plan have had their insurance go up over 100 percent in a 3-month period. In May of 1991, our retirees paid $64 per month. In October of this year, they will be paying $136 per month.

For retirees that are over the age of 65, the union paid for their portion of the supplement to Medicare. Today we no longer can afford to do so. The retirees must pay $19 per month for themselves and an additional $19 per month for their spouses.

These increases that our retired members are having to pay are very difficult. They are on a fixed income. They do not have anyone or any place to turn for help. They are at the mercy of a health plan, and that plan is going broke.

One of the main reasons for the increase in premium costs that the Union has witnesses is the cost-shift factor. The uncompensated care problem that is prevalent in the Nation is a cost to all of us.

In effect, we are paying hidden taxes in our premiums and in the cost of medical services. Insurers and providers have some way to recoup the losses that they may incur for uncompensated care. Therefore, they shift the cost in groups and unions like ours to private insurers. With Health America, the current cost-shift problems would be averted, as everyone would have access to the basic health insurance plan called AmeriCare.

Another important cost-containment measure in Health American is the Federal Health Care Expenditure Board. I understand that the function of this board is to bring together the purchasers of care and the providers of care to negotiate and establish fair rates for health services. This is similar to what happens now in labor negotiations and we have found this to be an effective way of attaining solutions to similar issues between business and labor.

Other cost containment provisions in Health Care America such as those which will reduce unnecessary care and administrative costs should have the effect of downsizing our overall health costs as well.

Another serious problem we are facing today is trying to continue health coverage for our unemployed brothers. Many of our members have exhausted all of the unemployment benefits, and can no longer afford to make self-payments to pay for their insurance. Health America realizes this.

AmeriCare would be available to all those who do not have health insurance through their employer. Unemployed members whose benefits have expired would not have to fear being uninsured. They could get basic, solid health benefits through AmeriCare until work was obtained.

This feature of AmeriCare is important because it will act as a safety net for our members, and our Nation's unemployed. If people who have coverage today lose that coverage, then the State and Federal Government also lose because of tax dollars will have to be used to take care of those people's needs through the various public assistance programs.

It seems to me that we live in a sorry state when a person has to choose between putting food on the table or providing health coverage for his family. This may seem dramatic, but in some cases this

is very true. There are many families in our health plan that cannot afford to do both.

Retirees are going without the things they need and so are the youth of this country. For a young person to go out and buy insurance is almost impossible. The cost is unbelievable, and the job opportunities that provide insurance are almost impossible to find.

The rising costs have not only affected the retirees, the unemployed, and the youth of this country, but every hard working American in this country.

Each day employers and employees are becoming more and more concerned about how they can maintain health coverage. The working people of this country can no longer expect the employer to provide health insurance in the light of the skyrocketing costs.

The employer finds it difficult to pass on the cost to the employees, but they have little choice. They also pass it on to the consumer in higher prices for products and services. Businesses are finding it more difficult to pass these costs on and still be competitive in the market place.

More and more Americans are finding what little bit of raises they are able to negotiate at the bargaining table is being eaten up by health costs.

Improved benefits that have been gained through collective bargaining increases have been implemented by Social Security and the rise of minimum wage, and have been eaten away by the cost of health care.

This country needs a cost containment plan, and it needs it now. Health America is the right step. I am glad, Senator Riegle, that you and your colleagues have said enough is enough and are working to stop this outrageous cost today.

Men and women of this country should not have to live in fear of becoming ill or wondering what is going to happen to their families. Children should be born with the best possible medical attention available, and we should all die knowing that we have had every opportunity to have the best medical care available. It is time we took care of all Americans in America. Thank you, Senator.

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

Senator RIEGLE. Thank you, John.

[Applause.]

Before going to our very distinguished provider panel, I want to make a few comments after hearing from our two business representatives and a labor representative, about the information that was in today's newspapers with respect to the shrinkage of the job base in our State and in our country, particularly in northern Michigan, about the story in the paper that I was referring to earlier.

I want to add a couple of other things to it, because it is very important that we juxtapose this problem with the health care system in the context of the problems in the overall economy.

They cross-connect to one another and they cannot be separated. In mentioning job losses in northern Michigan because of that story today in the front page of the Detroit Free Press, there also is in the business section of the Free Press today a story about a downtown Detroit restaurant in Greektown called "Nikki's." It

talks about this particular restaurant going into Chapter 11 because it is in serious financial trouble.

It goes on to point out all the other restaurants in Detroit that have closed down this year—including the London Chop House and the Caucus Club filing Chapter 11, a restaurant called Jimmy's on Woodward Avenue filing for Chapter 7 liquidation, and so forth. I want to make the point that this job shrinkage, and whether a worker gets health insurance at the job site or does not—most do—that is vanishing as the jobs vanish. This problem is throughout the State of Michigan, and throughout our economy.

Also, related to that are two other stories in the paper today that I want to also cite in this economic vein. One is out of the Lansing State Journal today. In the front of the business section it says, "Spending Slump Hits Big Retailers Again." And then there is an inserted box here of an AP story that says, "Economic Numbers are Looking Weak." It talks about unemployed workers filing new unemployment claims running at $421,000 again in late August, which is a very high number and a very mediocre productivity increase figure. And then just the general bleakness of the economic picture on the retail side.

Now, the reason that is significant is that obviously people spend their income to live. If they do not have much income to spend, it is not showing up at the retail sales level in terms of cash registers, whether it is at K-Mart, or restaurants.

In today's Wall Street Journal, there is a story on page A-2 on what is happening to car sales and how they remain in a slump in late August. It says here, "Early Summer Hopes Fade As Dealers Say Rebates Can't Ease Lack of Cash." It goes on to say how difficult the situation is in the automobile business, obviously very basic to our State.

What is this whole mosaic telling us? It seems to me if you take the economic train wreck that is occurring, the health care problems are superimposed on that. In fact, it is part of the problem, it is also part of the solution, assuming we can get to a system where we are getting good health care through to all of our people, not just some of them. At least we would have a healthy population able to go out and apply their talents and to get this economy operating at a higher level.

As these things interact back and forth, as the economic problems pile up in this global economy and lack of jobs and lack of income, us the growing difficulties of a health care system that is not functioning properly, and very expensive, very uneven in terms of its application, these two problems start to work in combination in very, very damaging ways to our society.

We have already heard illustrations of that so far among our panelists. Whether we are thinking, Duane, about your case, in terms of an unemployed worker with a splendid work record, who is out there now going down through the countdown of exhausting unemployment benefits; or we are talking about Pearl's company, a top flight, smaller company, that has been in business a long time now, and is faced with this trade-off of either continuing health insurance coverage or laying-off part of that work force and adding to this general economic malaise that is intensifying.

I take the time to say that only because if we are going to find sensible answers, we have got to take all the factors at one time. It is very difficult to do. Very difficult even to get the stories written in one attempt that start to add up all the pieces, and then try to make sense out of it.

I think in this setting today it is important to take the illustrations out of just today's news—just today's news that illustrate these points to help us give some way for us to set some markings for ourselves as to what the problems are and how we might work our way through them.

Let me now move to our provider panel, and I am going to introduce, again, all three of our witnesses there, and then go to each of them in sequence.

Dr. Charles Newton is the vice chairman of the Michigan Section of the American College of Obstetricians and Gynecologists. He has an obstetrics and gynecology practice in Grand Rapids in our State. He is going to discuss the bill's impact on access to health care, as well as the problems that physicians are currently facing with the current Medicaid program and the high malpractice insurance rates referred to earlier.

Then David Benfer, who is the senior vice president of hospital affairs at the Henry Ford Health Systems in Detroit. Mr. Benfer will talk about the increasing burden that uncompensated care poses on hospitals.

A recent GAO study, which included the Henry Ford Hospital, reported on problems faced by trauma units as a result of these costs.

The Henry Ford Health Systems is very progressive in their managed care programs. Mr. Benfer will also comment on the managed care provisions in our Health America proposal.

Finally, Mr. Dan Ellis Champney, who is vice president and general counsel of Health Plus in Flint will testify. With him is Dr. Eric VanDuyne, who is a participant and physician, and board member of Health Plus.

It is a health maintenance organization that has been in existence now some considerable length of time and providing managed care. They will both talk about how the managed care provisions of Health America would appear to them to work and how it might be effective in reducing unnecessary care. So, gentlemen, we welcome you all. And Dr. Newton, we would like to start with you.

STATEMENT OF CHARLES W. NEWTON III, M.D., VICE CHAIRMAN, MICHIGAN SECTION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GRAND RAPIDS, MI

Dr. NEWTON. Good morning, Senator. Thank you for the opportunity to testify on this bill. I am Charles W. Newton, M.D., an obstetrician and gynecologist from Grand Rapids, MI. I have been in private practice in this location since 1974.

A small percentage of my patients are on Medicaid; and on a volunteer basis, I also supervise a high risk obstetrics clinic, that deals primarily with Medicaid patients. I am also the vice chairman of the Michigan Section of the American College of Obstetricians and Gynecologists, which is comprised of over 970 physicians.

There are many problems with the health care system in America, but for me the most compelling concern is the basic dilemma of access to quality care. The problem of access to care has many facets. Two of the most basic are inadequate physician availability in underserved areas, and lack of adequate health insurance for a significant portion of our population.

Many communities in Michigan right now are without obstetric and gynecologic care. A survey by the Michigan Section of the American College of Obstetricians and Gynecologists in 1989 revealed that the number of obstetricians who have stopped doing obstetrics in our State is 58 percent.

Senator RIEGLE. You want to repeat that again? I think that is an eye-opener, even after we have all been sitting here for awhile. Would you say that again?

Dr. NEWTON. A survey in 1989 by our Michigan Section of the American College revealed that 58 percent of obstetricians have stopped doing obstetrics in our State. It also showed that the number of OB/GYN residents who trained in Michigan and leave the State is 37 percent.

Why do residents leave and obstetricians stop practicing? There are two main reasons. First, the risk of liability exposure is too high for many to accept. Although the premiums are high, the real threat to the physician is the law suit itself. In a 1990 survey by ACOG—which is the American College of Obstetricians and Gynecologists—it was shown that 77.6 percent of all obstetricians have had at least one professional liability claim filed against them. Exposure of this kind of risk drives physicians out of practice and reduces access to care.

The second force that diminishes access to doctors is low reimbursement rates. In Grand Rapids, Medicare reimburses at 20 to 50 percent of prevailing charges for health care services.

Two graduating residents from my hospital tried to serve the city of Grayling with obstetric and gynecologic care, but were unable to survive on the Medicaid reimbursement rates and were forced to leave. Most businesses could not survive at these rates.

Too many of our citizens lack health insurance altogether, and the Medicaid program that is currently in place has many problems, often causing delays and unattainable coverage.

With Medicaid, the usual eligibility denial for patients was due to failure to comply with procedural requirements. The client information system is also very difficult to access. The physicians find the Medicaid program difficult too. The "red tape" required to get claims satisfied is cumbersome and create excessive cost and time for physicians' offices. Most doctors are unwilling to deal with this hassle.

The Health America bill does address the problem of access to care. And I think the focus in the first year on pregnant women and children will be a tremendous benefit to this portion of our population.

With respect to physician availability, I feel the Health America bill needs to include more specific measures that would attract physician participation.

First, I am concerned about the proposed reimbursement rates for health services. Reimbursement schedules are planned to be similar to the present Medicare rates.

I am not sure how Medicare schedules will match up with services for pregnant women, but I hope that they are better than the present Medicaid rates so the physicians would be attracted to participate.

The bill also proposes the development and staffing of community health centers for underserved areas. However, it does not sufficiently address the basic problem of liability exposure. I feel the bill should incorporate specific measures similar to those outlined in Senate Bill 489 titled "Ensuring Access Through Medical Liability Reform Act," proposed by Senators Hatch and Jeffords.

For example, I feel that we should establish a system of voluntary or mandatory arbitration that would be binding. Also, a compensation fund should be established for individuals injured in the course of receiving health care to cover economic losses. A ceiling should be placed on non-economic damage awards. And we should set a schedule of percentage limitations for attorney contingency fees.

Cost containment is an important issue, as the cost of health care in our country is very high. This bill proposes practice guidelines and managed care as methods of cost containment.

Practice parameters are still being evaluated by the American Medical Association, and it is not clear what role they should play. Further analysis may reveal that they will reduce unnecessary care, but I feel there are potentials problems with strict guidelines and practicing medicine in a "cookbook" approach.

Who will write the guidelines? How many different human illnesses and conditions can be covered by guidelines? How often will the guidelines be changed and revised to keep up with the constant changes and improvements in medicine? What are the liability risks for physicians if practice parameters are utilized?

We do have some experience with managed care, such as HMO's and PPO's, and it has been shown to reduce costs. But quality of care can be easily compromised and patient satisfaction can be diminished.

A very positive aspect of the bill is the incorporation of preventive care measures—such as mammograms and pap smears—which have been shown to lower costs in the long run.

I support the concept of health insurance for every American, but the insurance does need to be "user friendly," for patients and for physicians.

The ideas in this bill for standardized claims forms and insurance consortia will potentially streamline the cumbersome paperwork that is needed now.

I also think the scaled co-pays will make the system more efficient by eliminating some of the unnecessary visits. I think some attention should also be given to educational and awareness programs for patients. Medicaid patients right now have very high no-show rates, and they are very often late to seek care.

Senator, in summary, I think this bill is a step in the right direction, and it addresses many of the problems in our health system, especially my concern for access to care. Although universal insur-

ance is a big part of the solution, it is equally important to have an adequate supply of willing and motivated physicians. Thank you.

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

Senator RIEGLE. Thank you very much, Dr. Newton. [Applause.]

Before going to our next witness, I want to just thank very much the two individuals who have been signing for us today. Sue Bahleda and Dorothy Tinney. It takes a lot of effort and we are very appreciative, both for the people in the room and those that will be watching this on television.

I also want to introduce the two individuals seated beside me and behind me here. On this side is Debbie Chang. Debbie works on our Washington staff with the Senate Finance Committee and has been, I would say, the chief professional staff architect of this legislative proposal. Although many have worked on it constructively, I think Debbie, who comes from Michigan and is a graduate of the University of Michigan, if I may say that in MSU territory, as an MSU graduate myself, has played a key role in that. [Laughter.]

And also, Kristin Johnston on this side, who is the person in our State office staff that is concentrating on the health care issues. They are a very important part of our effort to listen now and to do the hand tailoring, as I say, that is necessary as we go ahead.

I also want to say that we have had now over 300 people in attendance today in the audience. Some, of course, have had to leave, but that is a tremendous turn out on a week day for a matter of this sort. I think it attests to the importance of the subject, and the keen interest that there is in it by so many people. We all have an enormous stake in what is done here.

With that, let me now introduce Mr. Benfer, who has been a very important witness before us previously and has given us suggestions that we have been able to attempt to incorporate in this legislation. We are very pleased to hear from him again now.

STATEMENT OF DAVID W. BENFER, SENIOR VICE PRESIDENT OF HOSPITAL AFFAIRS, HENRY FORD HEALTH SYSTEMS, DETROIT, MI

Mr. BENFER. Thank you, Senator. It is a true opportunity for us to again comment on S. 1227, which expands access to health care by making basic health insurance coverage universally available to every American within 5 years.

This proposal balances cost and expanded access with new savings to be gained from standardized benefits and prices, global budgets, managed care, clinical guidelines, outcomes research, and technology assessment. The Henry Ford Health System supports the comprehensive direction of this landmark legislation.

A national health policy on access and cost is long overdue. We are grateful for your work over the past several years, Senator, in moving this debate forward.

We commend you and your colleagues for stating a policy position that everyone in America has a right to health care coverage, and for setting forth a proposed road map in S. 1227 to achieve this objective.

A key contribution of this legislation is that it clarifies a policy position on the financing of health services. First, responsibility for

employed persons and dependents, together with the economically self-sufficient, is assigned to the private sector. This is what the play or pay requirement for employers means.

Second, responsibility for the aged is assigned to Medicare. And last, responsibility for all others is assigned to AmeriCare with an expansion of Medicaid to include coverage of low-income persons. Such a comprehensive financing policy is necessary to achieve universal coverage.

You have asked us to comment on some of the problems in our urban area that this legislation will address, as well as provide suggestions on ways to strengthen this bill. A written statement has been submitted for the record that covers suggested changes for legislation.

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

Mr. BENFER. What we have asked for are new provisions in the bill that will encourage the growth and development of managed care capability in the delivery system. In addition, we recommend specific recognition in the bill of basic differences between managed health care plans that are funded by per capita payments, and those that are financed by fee-for-service payments.

Today, I will highlight the problems that will find solutions in the universal access guarantees of S. 1227.

The perspective of the Henry Ford Health System is one of a large regional health care organization that serves a diverse population in southeastern Michigan and derives approximately 38 percent of its total revenues through capitation arrangements in our HMO—Health Alliance Plan of Michigan.

The Henry Ford Health System is Michigan's sixth largest employer with more than 15,000 employees. The system includes 33 urban and suburban out-patient ambulatory centers, three hospitals—including the Henry Ford Hospital in Detroit—one short-term in-patient psychiatric hospital, one chemical dependency center, and major research and medical education programs. We provide about $25 million in research annually and educate more than 500 residents in graduate training programs.

Urban areas like the communities we serve in Detroit are subject to great stress from unemployment, homelessness, violent crime, drug abuse, and inadequate funding for education. All of these take a toll on our community. These social problems are reflected in the needs of patients who present themselves to us for health services.

S. 1227 offers new hope and a much needed safety net for this community that Medicaid and the private sector cannot assure.

During the 1991 Michigan State budget crisis, Henry Ford Health System began to track the impact of Medicaid reductions on Wayne County. Approximately 52 percent of all the cuts in Michigan Medicaid funding came from a service area immediately around Henry Ford. Of approximately $55 million in targeted savings state-wide, over $29 million of the reductions fell on Wayne County.

At the same time, these health care reductions were announced, large reductions in income assistance programs were also implemented, affecting approximately 40,000 people. Whatever the justification for these measures, economic reductions of this magnitude

in such a short period of time tears at the very fabric of the Detroit community.

Our Detroit urban catchment areas have chronic illness and infant mortality rates several times higher than the national average. Unemployment is high, incomes are low, and people are relatively young with low levels of educational achievement.

Often in our Detroit communities, we are in a position to provide emergency care and expensive hospital care when we would prefer providing health care. Lack of insurance and inadequate public funding results in limited primary care services for low-income patients in many States, as documented in the recent Physician Payment Review Commission Report.

In Michigan, Medicaid underpayment and charity care caseloads have clearly restricted low income patient access to primary care and have undermined the efforts of the legislature and the Department of Social Services to improve obstetrical and prenatal care. As a result of Medicaid underpayments to physicians and lack of insurance coverage, many urban hospitals have become the substitute for the "family doctor" in the urban community.

The Henry Ford Health System includes six 24-hour emergency facilities that have increasingly become the point of entry for the health care system for people without primary care insurance coverage. Without access to primary care, many low-income patients present themselves in advanced stages of disease that could have been avoided.

Current State and Federal policies tend to guarantee emergency care through the Medicare "anti-dumping" rules, but neglects primary and chronic care needs.

Senate Bill 1227 contains a dual strategy that will successfully address health care needs of low income in urban areas. First, enrollment in AmeriCare will provide payment for everyone below 200 percent of the poverty level.

In Wayne County, there are approximately 385,000 Medicaid-eligible individuals—one-third of all Medicaid eligible in the State. 50,000 are below poverty levels who currently are covered by a program known as County Care in Wayne County. another 250,000 people at various income levels have no insurance.

AmeriCare will provide an affordable opportunity to obtain coverage for this entire population of 385,000 people. AmeriCare means better health status for the community through new revenues and new access to needed services.

Second, the bill targets primary care access through the community health center expansion concept. Community clinics have proven to be a successful way to provide care in poor, urban settings where patients may be transient or may lack transportation.

In Detroit, public transportation gaps add to access barriers, so there is a special need here for local public clinics close to home. We strongly support the recognition and funding of community health centers in S. 1227.

The city of Detroit operates several clinics that are current overburdened, and additional facilities of this type are much needed, particularly during the 5-year phase-in period.

Because of the special needs of this population, you might also consider special support for home health outreach services, as well as school-based clinics.

As a system, Henry Ford Health System financed $21 million of charity or free care, and an additional $17 million in underpayments from Medicaid. The cost is particularly heavy at our urban facilities, where losses due to uncompensated care must be balanced by positive operating margins elsewhere in our system.

The financing of care to the uninsured by shifting costs to other payors—or what used to be known as "Robin Hood" financing—has become difficult, if not impossible.

Currently, approximately 90 percent of our revenue base is unavailable for cost shifting due to fixed payment arrangements to HMO's, government payors, or Blue Cross. Continued cuts in the Medicaid and Medicare reimbursement and eligibility restrictions make this problem worse.

Medicaid payment ratios for the Henry Ford Health System are about 55 percent of the costs of our out-patient services, and 41 percent of the cost of physician services. We subsidized or provided coverage for the loss of $12 million in Medicaid services for out-patient and physician services alone last year.

The Henry Ford Health System, in addition, is picking up more charity care costs from benefits and eligibility for State-funded programs are reduced, and because the organization has continued to serve this population which is adversely affected.

For some providers in Michigan, the erosion of employer coverage has also created new bad debt, because minimum wage workers cannot meet the deductible or co-payment obligations.

Universal access means that urban hospitals and physicians will no longer bear a disproportionate share of uncompensated care. Under S. 1227, the Medicare payment rules for hospital and physician payments will be the new standard for both the public and private payor. With the parity of payment rule in S. 1227, underpayment by the public programs will disappear.

Parity in payment solves the uneven distribution of charity care cost problems, but it also opens new opportunities for better health status. Expanded access to primary care means earlier intervention in chronic disease, and lower costs for emergency care.

In many ways, Senator Riegle, the new access to primary care represents one of the most important cost-savings elements of this legislation. The best example I can offer has to do with low birth weight babies and what it means to the cost for society and the health care system in terms of quality of life and cost.

Recent studies of the success in the United States of reducing infant mortality rates document that little progress has been made in improving birth weights of babies.

Birth weight is the best indicator for long-term health of the infant, and is directly related to good prenatal care. Without good prenatal care, we tend to see very small babies delivered prematurely, requiring intensive medical care for long periods of time.

Census in our neonatal intensive care unit at the Henry Ford Hospital and other hospitals in Detroit is higher than the rest of the State. Better primary care before birth will help to lower this cost.

The latter sections of this legislation spell out managed care as a preferred strategy under AmeriCare. These sections constitute critical strengths in the bill.

By establishing managed care as Federal and State health policy, the legislation helps untangle the problems that many States encounter in trying to obtain waivers to allow Medicaid agencies to promote enrollment of patients in managed care plans.

Proposed financing incentives through the enhanced payment rates for States that achieve a high percentage of AmeriCare enrollment in managed care plans is an effective way to implement this policy. We support the policy direction and commend you for an important contribution to cost-effective, high quality care for low-income patients.

Managed care is uniquely a U.S. contribution to health care. Ways to encourage the growth and development of this built-in U.S. strength should be a high priority. By focusing on the patient rather than the service, managed care offers real opportunities not only to save money, but to assign responsibility to local health care providers for cost-effective health care in a designated geographic area, like the urban area of Detroit, or for a defined population, such as children or seniors. This is an excellent strategy to improve health status of the covered population.

To the extent that managed care occurs today, it is an achievement of physicians and hospitals, not insurance companies or other third party payors. Insurance mechanisms provide critical incentives—or disincentives—for the delivery system to respond with managed care.

By the requisite integration of services, with an emphasis on primary care, they cannot be developed without decisions and actions by providers to address the needs of patients through a managed care delivery system.

You may want to consider amendments to the bill that encourage Federal and State governments to inventory regulatory barriers that inhibit growth of managed are and regional health systems, such as anti-trust laws and fee-for-service payment practices, and set a timetable for addressing these barriers. Otherwise, managed care as a national cost-containment strategy may fall short of the savings needed to pay for the expanded access.

Henry Ford Health Systems supports universal coverage and the extension of tax benefits to small businesses.

We support the policy on fairness with regard to maximum out-of-pocket expenses. And under the bill, out-of-pocket expenses would be governed by the ability to pay with very low income people paying very little, and higher income people paying a maximum percentage of premium costs. This policy helps minimum wage workers and makes the overall financing approach more progressive.

The goal of fixing the current insurance-based problems that exclude people, by phasing out insurance underwriting—such as exclusions and limitations, which you heard of earlier—are all health coverage plans. And the return to community rating is a most welcome policy direction.

Malpractice liability remains a substantial burden for health, even with universal access. There is great potential for savings in

Michigan where malpractice costs are approximately three and a half times the national average on a State-wide basis, and in Detroit, up to five times the national average.

Lack of insurance availability which results in lack of specialists available to serve patients is a critical problem. Temporary, partial and permanent closure of some emergency rooms throughout Detroit creates a domino effect on remaining facilities.

Liability constitutes a serious deterrent to adequate coverage in the Ford System where we must rely on community physicians to respond in our suburban hospitals to emergencies. Direct and immediate action is needed to address overall costs and dangerous service disruptions that liability creates for emergency and obstetrical care.

As an example, if our malpractice rates were equal to that of New York, we would save approximately $67 million in Southeastern Michigan. That would be enough to provide coverage similar to the County Care program to up to 50,000 people.

It is unclear how medical education and medical research will be supported under the legislation. These are sensitive areas necessary to maintain high standards of quality in the health care system. Current funding of these areas is integrated into the regular payment mechanisms, and any shift from integrated funding to segregated funding for education and research may be difficult. The transition period merits special attention for vulnerable urban institutions like the Henry Ford Hospital, with sizable responsibilities for medical education, research, and service to low-income patients.

Senator Riegle, we commend you for setting the direction for America's health care policy. Thank you.

Senator RIEGLE. Well, thank you very much. [Applause.]

We have one more important witness here. I want to make a comment before we go to our final witness, and that is you mentioned prenatal care, and you mentioned these under weight babies.

One of the things that we are finding throughout the health care system in Michigan and across the country is that the absence of prenatal care for expectant mothers—which is a very widespread problem—in many cases, leads to premature births and to low birth weight babies. Medical technology and the skill of our health care professionals is now so extraordinary that we routinely are able, in many cases, to, with great effort, save the lives of premature babies that are born with weights as low as, say, 2 pounds. And until you have seen a 2-pound baby, it is hard to imagine how truly tiny they are.

But I have been visiting a number of these neonatal units in hospitals across the State. In Flint, for example, at the Hurley Center, there is a very major neonatal unit.

In that unit today, if we were all to go there, literally would be dozens of incubators where low birth weight babies are now, receiving the extraordinary medical care that science and skilled practitioners allow us to give.

It is very expensive care. It costs about $1,000 a day. A 2-pound baby that spends 100 days in the hospital to get up to maybe the normal birth weight of 6 or 7 pounds, or something close to that

where they can then go home with the mother, normally costs about $100,000. So, if we could take in situations where some prenatal care that the expectant mother is not getting, were she now to get that and enable, in the case of that pregnancy, the baby to go to full-term, the baby might be in the hospital 2 or 3 days, and then going home at a more normal birth weight.

When you think about the $100,000 expenditure—and I have seen premature babies still in the hospital months later that I have referred as "Million Dollar Babies," and who have never been able to reach the point of being strong enough to go home and are there and receiving the care as they should, and the cost just rising.

When you think about $100,000 spent in the first, say, 90 or 100 days of life, if we could find a way, through prenatal care, at a fraction of that cost, that money could be used to send that same child later on in life to Michigan State University for 4 years, or to Harvard University, or to Stanford, or what have you.

When you think about that kind of an expenditure—and many of these babies are covered under Medicaid, so that becomes a public expenditure that all of us pay.

But you start multiplying that by dozens, and then hundreds, and then thousands of premature babies with a different kind of a health care system in a good number of those cases who could come in at a normal birth weight.

By spending a tiny bit of money on the front end, we can avoid a very major expenditure that we are now spending later on down the line. And so, I think there are great savings to be achieved with a health care system such as we are talking about here.

There tends to be a focus on the cost. We have got horrendous costs now. There are a lot of costs that a revised system will save us, in addition to the heartache. We have heard examples of heartache today, as well.

Beyond the heartache, and just the sheer economics of the issue, there are billions of dollars to be saved by an intelligent health care system that allows us to get proper care, preventive care, prenatal care, particularly, earlier into the picture. That is part of what we do with our initial phase, although I must say that I agree with the testimony that we received earlier.

I think persons with a severe health problem or pre-existing illness ought to also be coming in right off the bat. I would like to have a program where everyone comes in for coverage immediately, but I do see the necessity just in the sheer mechanics of having a policy by which we move from the system we now have in some set of steps to the new system.

Finally, let me now call on Dan Champney, who is the vice president and general counsel of HealthPlus. And let me also say that Dr. Eric VanDuyne, who is with him, I have known Dr. VanDuyne now over a quarter of a century before either of us had any gray hair. We are both getting it quite rapidly these days.

I know Dr. VanDuyne to be one of the fine physicians that I have met in my time. They have been in the lead with respect to managed care, with respect to how that works and what the advantages of a health maintenance organization can be, as well as the effect it can have on reducing unnecessary costs.

We are very interested in their perspective on the legislation that we have designed here. So, gentlemen, why do you not proceed, and share the time however you wish.

STATEMENT OF DAN ELLIS CHAMPNEY, ESQUIRE, VICE PRESIDENT AND GENERAL COUNSEL, HEALTHPLUS, FLINT, MI

Mr. CHAMPNEY. Thank you, Senator. It is truly an honor to have the opportunity to comment upon Senate Bill 1227—the Health America program.

The health care delivery system in this country, and specifically in the State of Michigan, is itself in poor health.

And, I dare say, Senator, that throughout the hearings that you will have on this bill, that you will not have anyone that testifies and tries to support the entire system as doing a good job.

And I think that your graph on the audience's far left certainly demonstrates that. Just about anyone who does an analysis of other industrialized countries and compares what we get or what we spend, reaches the same conclusion.

The point that I think should be recognized today is that very few who have noted the bleak comparison have suggested reasonable solutions. And for that reason alone, Senator, you, as well as Senators Mitchell, Kennedy, and Rockefeller and their staffs are to be congratulated for your efforts.

There will be two parts to my testimony this morning. First, I would like to share some of the history and experience of the company that I represent, HealthPlus of Michigan.

Second, I would like to offer some comments relative to the role of managed care in the Health America package. I am also sharing my time with Dr. VanDuyne, who will comment upon the Health America proposal from the prospective of a physician operating within a managed care program.

HealthPlus of Michigan is a federally qualified and State licensed health maintenance organization. As an HMO, HealthPlus arranges, through contracts with physicians in independent practice, to provide specific benefits to our members in exchange for pre-payment from employer groups.

Like many HMO's around the country, HealthPlus has not been in business for all that long a period of time. We enrolled our first member in the fall of 1979, but have now grown to over 100,000 enrollees. In addition, through two subsidiary corporations, HealthPlus also now offers non-HMO type benefits, such as self-insured programs and low-cost insured options. We continue to try to develop new products to meet what is a very rapidly changing health care landscape.

Common to all of our products, however, is the concept of managed care. It is the very concept that is an integral part of the Health America program. While HealthPlus has its roots in Flint, MI, it has now expanded to encompass a service area from Bay County down through Monroe County, and consequently provides health care coverage along the I-75 corridor; a geographic location with very unique health care characteristics.

As Dr. VanDuyne can testify, HealthPlus was founded through a very broad community task group in order to foster competition in the delivery of health care in the Flint market.

This task group had representatives from the medical community, employer groups, and organized labor. They saw a need and played a very key role in the establishment of a managed care entity which could bring some order, control, and efficiency to the delivery of health care in the Greater Flint area. We believe that these original goals have essentially been met.

Over the past 12 years, HealthPlus has acted as a catalyst for change in the way that health care is delivered in the Flint and Saginaw communities.

Some of the more direct consequences of our actions in the service area are as follows: One: utilization of appropriate care settings. Since its initial operation, HealthPlus has seen a reduction in acute in-patient use of greater than 60 percent. This has been a result of the focus upon the appropriate setting for necessary care.

The appropriate setting for the rendering of necessary care is not always an acute, in-patient hospital setting, but rather, may be an extended care facility, skilled nursing facility, or, even perhaps the patient's own home.

Two: negotiation of managed care contracts with our providers.

Senator RIEGLE. Now, let me just stop you there for a minute, Dan, because you have used some important phrases that I know have a special meaning and are sort of a term of art. When you say the proper setting for necessary care——

Mr. CHAMPNEY. Yes.

Senator RIEGLE. Give us a general definition of "necessary care" to give us a framework.

Mr. CHAMPNEY. Perhaps it could be best explained, Senator, by talking about some examples.

Senator RIEGLE. All right.

Mr. CHAMPNEY. If you have a relatively insignificant health problem, you may not be in need of being in a hospital.

Senator RIEGLE. Right.

Mr. CHAMPNEY. It may mean being seen on an out-patient basis will be appropriate for the particular care that you have.

Senator RIEGLE. Right.

Mr. CHAMPNEY. There are some standards that do exist nationally which attempt to look at the signs and symptoms of a particular patient and compare those to the setting that they would be in. And HealthPlus does subscribe to, and, in fact, use those standards in trying to make those decisions.

Senator RIEGLE. Now, I gather, though, one of the hundred thousand people belonging to your HMO, if they think they are sick——

Mr. CHAMPNEY. Yes.

Senator RIEGLE. They have got manifestations that tell them that they are sick—a fever, or pains that do not go away, or some aggravated condition—they would come to you and then from that point you would decide where to next.

In other words, the necessary care threshold does not stop somebody from coming when they feel they have got a medical problem. They are welcome to come, they do come, and it is the question of where they are routed after that point, is that right?

Mr. CHAMPNEY. Right. And our system is really based upon—and several other panelists have mentioned it—the unique role that a primary care physician can play in seeing his or her patient.

As I will comment later on, you cannot approach this problem and think that a master computer, or even someone with a business degree is going to be able to solve the problems of health care.

And, I think as our representative from Henry Ford System—the point that he made is that the real management of care takes place between the provider of care and the patient. And the key may well be in providing the appropriate support that that provider needs to, in fact, do that job.

Senator RIEGLE. Why do you not continue?

Mr. CHAMPNEY. All right. The second thing that we have been able to do is the negotiation of tough managed care contracts. And what we mean by that is contracts that not only provide for a fair or discounted rate, but also involve the provider of care very directly in providing care in an efficient means.

In addition, by its very nature, the negotiation of a provider contract involves a selection process by which a preferred panelist is derived. With the concept of a select provider panel comes the advantage of better management for the delivery of care, as well as an assessment of who are the appropriate providers to provide care for our membership.

The third point to emphasize is the assimilation and use of a credible data base. Because of the controls and contractual basis behind the business, HealthPlus has been able to implement and maintain a credible data base. Trying to make any progress in the delivery of health care without credible data is an exercise in futility.

Now, beyond these very specific effects that HealthPlus has had in its service area, there are a variety of indirect benefits to the community as a whole.

One quick example. If a physician is made aware of the relative costs of different pharmaceutical products with equivalent efficacies, the practice pattern toward the more efficient drug may be adopted by the physician, whether or not a managed care patient is involved, or not.

The same could be true concerning the selection of a specialist, or the availability of other community resources to help the patient. I think what that comes down to is that, despite the very high cost, many times the actual practitioner is dealing with a lack of information in terms of appropriate measures, and which one of those measures is actually the most cost effective, or even the best quality product.

Having spoken now concerning the HMO industry in general, and HealthPlus specifically, let me devote the remainder of my time to focusing upon Health Care America. We are very pleased with the predominant role that managed care, both as an industry and as a way of doing business, has in this legislation.

Managed care has the best chance of simultaneously considering the cost, quality, and availability of health care to Americans. Some have suggested that cost and quality are on the opposite ends of the health care delivery spectrum. This is simply not true.

More care and expensive care is certainly not necessarily better care. Over-utilization can be as damaging to a patient as under-utilization. Managed care focuses upon the right care, in the right setting, with the right result.

The delivery of health care, like any other industry, must be looked at critically and analytically, utilizing the best possible data available to make knowledgeable, and certainly difficult decisions.

The managed care entities have the best potential for doing this, since, by their very nature, they involve the essential players: the purchasers, the providers, the patients, and the administrators.

We are similarly very pleased with the structure of the act, which, from our reading, at least, allows the natural competitiveness of health care delivery to play a significant role in the program.

It would certainly be a significant mistake if the experience gained by managed care entities around the country were lost through any type of national legislative mandate for a single payor administrative structure.

Once again, our reading of this legislation would lead us to conclude that a single payor system is not being advocated for the whole program.

Next, HealthPlus believes that the Health America Act would have a greater potential for having a positive impact in the State of Michigan with a more active challenge to the problem of medical malpractice.

In the State of Michigan, the managed care movement and the medical malpractice movement seem to be on a collision course. I do not believe that there is a single physician, either participating with HealthPlus, or practicing in southeastern Michigan, that does not sense an enormous rain cloud over their shoulder as they practice in a managed care setting.

In conclusion, HealthPlus believes that the Health America Act is a bold initiative, founded on sound and correct principles, launched with the hope of bringing some order and control to the health care system in this country.

We look forward to working with you, Senator Riegle, and others, toward meaningful solutions in this area. Thank you very much for the opportunity to express our views. And I would like to give the remainder of my time to Dr. VanDuyne.

Senator RIEGLE. Thank you very much. [Applause.]

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

STATEMENT OF FREDERICK W. VANDUYNE, M.D., PARTICIPANT PHYSICIAN AND BOARD MEMBER, HEALTHPLUS, FLINT, MI

Dr. VANDUYNE. Good afternoon, Senator Riegle. I believe it is afternoon. I am honored to be able to comment on this bill—the Health America bill. My name is Frederick VanDuyne. I am a solo family practitioner, and have been in practice in Flint since 1960.

I have been involved in the political process, I have been involved in hospital governance. I have served several years on the Michigan licensing board; and, more recently, have been involved in the creation and implementation of peer review and quality as-

surance, the SRO; and ultimately, as Dan Champney has indicated, was instrumental in the formation of HealthPlus of Michigan—served on its board, and continues to serve as one of its medical directors.

Senator RIEGLE. Can you pull that mike a little closer? I just want to make sure that people can hear you throughout the room.

Dr. VANDUYNE. All right. Thank you. This has been a very interesting morning. I think I have learned a lot hearing these people, and being last on the program has some disadvantages—particularly following a lawyer—but it has some advantages. And I have been sort of changing what I am going to say here, so my remarks are not fully covered in the text that you have.

One of my other accomplishments, on a personal note, occurred back in 1965, when, in my capacity as a Republican chairman of the Gennessee County, I made a phone call to Massachusetts to a Mr. Don Riegle, Jr., and asked him to run for Congress. And he did, and, of course, the rest of that is history. So, it is kind of fun to sit here and talk to you in this capacity, Don.

I certainly do not need to go over all of what has been said about the Health America bill, and more and more today, I like it. There are a lot of things in it that address the problems.

I like, particularly, the fact that it will do away with the pre-existing condition problem that is totally unfair to patients. The maintenance of managed health care is a part of it. We may have some competition trying to address some of the administrative burdens and the technology assessment that everyone else has talked about.

Let me give a couple of cautions from my perspective, really, as a primary care physician, because that is what I do most of the time. Having been on the licensing board for 12 years, and having served in these peer review entities over a period of 17 years, I am aware that there have been, and continue to be, physicians who economically abuse our system.

My caution is that we do not create a system that is so punitive and inflexible that the physicians who try to be cost-effective are unable to deliver needed care.

And your question to Dan about what is necessary, I will comment on a little bit further down, because I think that is a question that a physician needs to talk about a little bit.

Managed health care is successful in eliminating so-called unnecessary care. As Dan has indicated, we, in Flint, have lowered the hospital utilization some 60 percent over a period of 10 years and the savings there are quite obvious.

In fact, I serve as chairman of the Quality Assurance Committee of HealthPlus, and in the past 2 or 3 years, the majority of the time that we spend in dealing with physicians have more to do with their failure to perform tests and do certain things rather than their over-utilization. Let me comment on that a little bit.

HealthPlus has adopted over the years certain standards, particularly as it regards preventive medicine, such as mammograms, sigmoidoscopies; that sort of thing.

When we apply those standards to our physician population, we find that, in general, 40 or 50 percent of the time the problems are that the physician is not doing the tests that he ought to be doing.

And I mention that because, although I am fully in support of standards and parameters—and you should understand that HealthPlus is in this I-75 corridor which has got a utilization rate second to none in the Nation, as you know—or at least it did have.

And we are also in the scenario where there is good access. All the patients in HealthPlus have primary care physicians, it is covered so that the utilization of these standards, which you would expect to be very high, when, in fact, it is not.

So, if you take those standards or parameters and we adopt them and apply them across the board, you are going to find that there is a significant possibility that the use of those standards in applying them equally to everybody—which is, I think, what we are after—could, in fact, raise health costs.

And I mention that because I do not hear anybody really talking about that possibility. My experience would indicate that that is what you tend to run into.

In response to this question of medical necessity, let me take you into my office very quickly and give you a little insight into how physicians make a decision to spend money by ordering tests and treatments.

Senator RIEGLE. Right. That would be very helpful.

Dr. VANDUYNE. Because it is really not the clear-cut situation you think it is. Let us talk about headaches, because everyone in this room has a headache. I am sure some of you have a headache right now. I do. [Laughter.]

And statistically, some 60 or 70 percent of you will consult your physician about a headache during your lifetime, so it is a rather simple example. When you come into my office, I will spend some time asking you what that headache is about; how long you have had it; how severe it is. The success of that dialogue depends a lot on how articulate you are in emphasizing the various symptoms and answering my questions.

How successful we are in reaching some agreement as to what to do depends on whether I am in tune to what you are saying, to your body language, tone of voice; all of these intangible things that go into this decision.

Then I will examine you and we will decide how to treat this headache. It may be aspirin, and take a little more time off from work, it may be the ordering of several thousand dollars worth of tests and consultations, MRI's, and so forth. Or, in some cases, it may mean hospitalizing you because of the particular characteristics of your headache.

Once that decision is made, my office staff then gets involved in an incredible array of phone calls, authorizations, to get that care approved and to sort of get the ball rolling. Those are surmountable, and in a HealthPlus scenario, we have cut those to a minimum. But when dealing with lots of entities, it can get quite complicated.

Even of more concern is that there are review entities—such as EMPRO, Blue Cross and Blue Shield—who may then look at my decision to do that test by looking at data, by utilizing people who have never seen the patient, who are not privy to the dialogue that you and I had.

Senator RIEGLE. Right.

Dr. VANDUYNE. And they will make a decision that that was an unnecessary test, and they will start to either get the money back, or to sanction me for doing that.

There are still other variables that occur. If your Aunt Susie had a headache a year ago and has since died of a brain tumor, you are going to slant, or emphasize your testimony to be darn sure that I do not just give you aspirin, that I, in fact, order that MRI. You can see how variable that is.

Senator RIEGLE. Yes.

Dr. VANDUYNE. If Aunt Susie's physician was a friend of mine and was sued by the family for not doing that MRI, that is clearly going to affect what my ultimate decision is going to be as well. So, my point is it is very hard to quantitate that in a data base or with a computer, or from the aspect of economics solely. If the reviewing entity disagrees, then I may be sanctioned, and, in many of these instances—EMPRO in particular—I will never have the opportunity to talk to a physician—a peer physician—to explain to him why I did that MRI on that particular set of circumstances on that particular day.

Senator RIEGLE. Who do you talk to? Do you call and get a computer voice over the phone, or do you talk to a technical analyst?

Dr. VANDUYNE. Well, it is not necessarily a computer voice, but it is a faceless voice. It is someone who may not understand the technical terms. In HealthPlus, when we have disputes with physicians, we end up sitting down face to face with a pile of charts and going through them and asking that physician to explain, well, why, under these circumstances are you doing this test?

Senator RIEGLE. Right.

Dr. VANDUYNE. A tremendous education process occurs. It is not particularly punitive. Now, if the physician continues to ignore the suggestions, then punitive action can certainly follow. But there is a tendency under the existing system—and you have to watch that in the future—to act countermanding this determination of medical necessity.

And I raise that because you may or may not be aware that recently there was a suit in this State against the Insurance Commissioner of Blue Cross/Blue Shield that had to do with who determines medical necessity; and secondly, what are the appeal rights of a provider; and thirdly, does Blue Cross, in this State, truly fulfill the goals of access, care, and quality? That case was won, and is going to be in the Appeal Court.

It is important because it goes to the question—as Dan Champney said—what is medical necessity, and who determines it, and under what circumstances?

Senator RIEGLE. Yes.

Dr. VANDUYNE. So, with this rather simple example, I just want to emphasize two points. A malpractice scenario has been well-documented here today. It is not just the premiums, and it is not just the threat of it.

It is the hidden defensive medicine costs, and we estimate those to be somewhere in the area of 10 or 15 percent. And my example of the headache, I think, illustrates how that can happen in the decision process.

The second is the over-lapping administration, and I think your bill begins to address that in a very positive way. Again, my advice would be to try to keep that as much on the local level when you get down to the punitive and sanctioning part——

Senator RIEGLE. Right.

Dr. VANDUYNE [continuing]. So that the physician has an opportunity to discuss what he did and why he did it.

The third area I want to just touch on is the cost of the care of the terminally ill. The issue of prioritizing and rationing—if you choose to use that word—and the assessment of technology and the cost/benefit ratio of technology. All of those things are in your bill, and I think they are excellent.

My caution is this: even with that, you cannot expect the individual physician to solely be the rationer.

In other words, you cannot expect me to decide not to do a test on an individual because the cost/benefit ratio turns out to be too low. To do that, you need to spend—you, being the political entities—some time in addressing that on a national level.

Senator RIEGLE. Yes.

Dr. VANDUYNE. The political entities, society, in general, has to be behind the physician if we are going to implement that kind of cost containment of rationing.

And, finally, the legal system cannot be allowed to continue to look over my shoulder, and if I make a decision to not do a test because the cost benefit ratio is astronomically bad, that if I make that calculated risk and then I am wrong, I will be sued, whether it is malpractice, or not.

So, in summary, the more I have learned about this bill today, the more supportive I become. It really gets at all of the areas that need something done. I think it is a good start down that road to a fair and cost-effective system that is available to all of us.

My emphasis would be on the malpractice, the administrative nightmare, and addressing the care of the terminally ill. Thank you.

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

Senator RIEGLE. Thank you, very much. [Applause.]

It is a wonderfully instructive and helpful commentary and testimony and I want to make a couple of points about the insurance system, because we all have to deal with it, and it is very hard to understand. But the nature of the way the insurance system works in the United States, whether it happens to be medical insurance, or car insurance, or whatever kind of insurance it is. We do not regulate insurance in our country at the Federal level.

We do regulate a lot of things at the Federal level, but insurance is not one of them. It is sort of an anomaly in our financial system and insurance is regulated at the level of each of the 50 States, and each State is different in terms of its pattern of insurance regulation. There is a whole body of law in history and practice as to how that came about, and why that is the way it is.

And, in fact, there are even some people that now suggest that it is time to bring the regulation, if you will, of insurance, up to the Federal level and to make it uniform across the country, and so forth.

As you might guess, with an established pattern the other way, that creates a tremendous, automatic tension as to whether or not you are going to change the status quo.

It comes into play in the question of how we address the insurance aspect and the medical malpractice aspect in health insurance, because you start with a situation where the fundamental regulatory primacy of insurance is at the State level, as opposed to the Federal level. And so, that is one of the first issues that you have to encounter and deal with.

There are some ways in which that can be dealt with, in part, at least, at the Federal level. But it is not a clear-cut situation like it might be if it were a different kind of regulatory structure in place today.

Also, in my mind, today is an exercise in democracy. We all wonder what democracy is and how we get our hands on it, other than going to vote, or maybe running for office, or supporting someone, if we are so inclined.

Democracy is really a slow, difficult, tedious process. Our engineering design in the government itself is designed to make decisions hard to make.

The founding fathers and mothers, in their wisdom, put together a system which divided powers very thoroughly in order to prevent people from collecting too much power at one time in order to do too much, too fast, in the name of government.

We are very much a government of divided power, and it takes a long time to collect enough power within our system, coming from the citizenry, up through our governmental structure, to be able to have a working consensus and enough momentum to go in and actually make something happen.

There are a lot of things that are designed to slow the process down and to make it difficult to accomplish just so there will not be "abuse" by government.

That was the whole slant of our government as a democracy to try to get away from kings, queens, dictators, and autocrats.

We have developed a very equalitarian and divided power system. When suddenly we have a very complex problem to solve, it is awfully slow going to actually get enough of the mechanisms of government working together and in synchronization to actually get something done.

The longer we wait and the more difficult and complex the problem becomes, the easier it is to do nothing about it. I mean, maybe talk about it, or complain about it, or whatever. It gets harder and harder to deal with, because elements of the problem become so entrenched in a certain way that it is very, very difficult to break the inertia and get going.

In that sense, this proposal that we have been talking about today is an effort to try to do that in the health care area, as we all know. It is far from perfect.

It is an effort to try to take and bring together the whole mixture of issues which have all kinds of inherent conflicts in them and to sensibly, and rationally, and fairly try to reconcile them; try to sort them out, solve them one by one, item by item, and then in combination.

It is almost impossible to do, quite frankly, and that is one of the reasons we have not done it for 20 years in this country, even though we should have, and we need to. Every day that passes, we need it in a more urgent way.

What I think is so powerful about today's hearing as an exercise in democracy, in terms of all of us thinking together about what it is we want to do, and how to do it, is that we have started out today with people who need health care, and who are the users of the health care system, or need to be—must be, then we have come through, in essence, the business community where people work, and where most people today get their health insurance coverage and the problems that are involved there in terms of that essential union and juncture of interests.

Then we have heard from some providers of health care services who are in this loop, and who are trying to make sure that what we need to have in the way of health care services are there for people. How we match ourselves up, how we collect ourselves as a nation of some 250 million people so that the things that get done need to get done, so that those that need the help can get it from those who have spent their life training to deliver the help.

Essentially, that is the way our system has been engineered—through the workplace, through the private sector. One can talk about different models, and so forth. That is the one that has grown up in this country. That is the predominant system that is in place today. There was a lot of discussion among just the four co-sponsors of this legislation about what kind of a conceptual model do you structure? In other words, do you take the existing system and try to take and re-engineer it—take the best features, try to deal with the problems that have grown up in some of the worst features, the contradictions, and so forth—and move in stages from what we have to a new system that we think could reach everybody and be more cost effective and more cost efficient.

Some people say it is better to just scrap this system—although I question the practicality of that—and go to a brand new system that is a radical departure that would be more on the model of what some other countries have.

Once you take that out of the realm of debate and bring it down to the practical realities of going from A, to B, to C, to D, in terms of actually going through the steps, it is a much harder proposition. Not that it cannot be done, and not that there is an advocacy for it.

We may end up waiting too long to deal with the problems in the system now, and that may be well what happens, because people finally become so frustrated that you get revolutionary change as opposed to evolutionary change. Sometimes it works better, and sometimes it does not. One never quite knows where you are in the course of those dynamics.

What this legislation is, is an attempt to take each one of those issues, put it on the table and propose a way to deal with it item-by-item, and then all items in together.

It is awfully complicated, I must say, and it sort of overwhelms my brain from time to time to keep all the mechanics straight because it is such a diabolically complex system that we have developed here.

It is very difficult to be able to capture the problem in all of its dimensions and reduce it to writing to clearly understood points and be able to think about what the re-engineering ought to be like.

Because we are all human, it is a human process and it is subject to the fallibility of all of us working on it, including the judgment calls—good or bad—that a given physician might make when somebody walks in with a headache, as Dr. VanDuyne points out.

I think there are some things, however, we can agree on, and I hear this common message today. Number one, it is certainly time to act. Secondly, we have got huge problems out there that are not correcting themselves and that need attention and need corrective action and change.

I am going to take the comments that we have received today and analyze them all very carefully. I may want to follow up with individual ones of you to pursue certain of the points that have been raised. I want to bring these to the attention of my colleagues on the committee, subcommittee, and the Senate as a whole.

We will continue the process of refining this legislation, attempting to take citizen input—including what I will also be getting and seeking from those of you in the audience that are not making formal oral presentations. Then, we will try to take and craft from this because in the Senate I need 51 votes. I can vote one of those 51 votes, but I have got to find 50 more.

Everybody has got a different vantage point, cutting and fitting to try to accommodate the need to obtain a working majority, because that is the nature of our democracy, and that is the iron law that in the end, everything has to pass.

So, I will be endeavoring in every way I can to take the ideas and the insight that you are helping us acquire to try to craft it into a working proposal that actually can become law.

Now, what is our plan for this? I am determined—within the bounds of what is humanly and physically possible—to get this done. It took me 8 years even to get on the Finance Committee, because for a long while they would not let Senators from industrial States get on the Finance Committee. That is a whole other story. But finally, Russell Long left the Senate, and I took his seat on the Finance Committee.

So, I got to go on the Finance Committee and then was able to persuade Senator Bentsen, who is the chairman, to form this subcommittee so we could get started with the practical job of figuring out how we tackle this problem and fix it as best we can, with all the limitations of how a democratic process works.

Now we are quite far down the track. We have got a proposal. We have got four Senators that have worked very seriously on it. We have got other co-sponsors of this package. We hope to induce another option or two out of some of our other colleagues to put on the table so that we can take our best thinking, and whatever best thinking that they have and blend those into something that can build the level of support that it takes to get this done.

We need public support. In this country, the country oftentimes can have big problems it needs to deal with, and it will not deal with them until the public really demands action; not passively, but in an active way.

And it is very important to build the strength of public feeling that says it is time to do something in the health care area. If the inertia that is now present does not prevail because there is not enough public perception of interest in the issue or enough public push to have it done, then problems languish, and the energy goes off some other place.

I think the energy ought to be focused right here in a very intense way. If we push very hard as a citizenry, whatever our political affiliations, or background, or philosophy, I am confident that we can get it done.

We have people in desperate need for this problem being solved; some of them are here in this room. I am looking at one right now.

This problem is not going to wait for the people who desperately need the help. That is why there is a real urgency for us to mobilize ourselves as a citizenry and talk through our differences, get them out on the table, get around the table, work them through until we have answers that we think are the best we can get, and put them into place, and go on from there. Then as we need to make adjustments further down the line, make those adjustments, too, as they may be required.

So, I would ask you to do that. I am not telling anybody to do it, because I would not presume to do that, and that is not the nature of our democracy.

What you decide and the level of effort that you want to give to a purpose of this kind is part of the genius of our democracy.

I would hope that we could continue to build the level of public support and effort to get this done. I am going to say one other thing, and then conclude here today.

It is very interesting. If I may, I have just a final personal note—it was 25 years ago that I first met Eric VanDuyne, and I was a member of the other party at that time. I gather you are still a member of that party, as far as I know.

Dr. VANDUYNE. Yes.

Senator RIEGLE. I changed my party affiliation along the way, but it is so interesting, because your interest in public service, and mine, brought us together at that point.

And here we are, a quarter of a century later, back working together, putting our minds together on an issue for exactly the same end. In other words, to see what can we do to try to make things better in this country, and try to help people along the way. That should be the spirit in which these things are done.

I think we over-emphasize party, and party differences—not that they do not exist and are not important—but there comes a point at which they ought to have their part, and then they ought to go to the side. Then we can get down to getting some things done that are good for the country as a whole. Where the points are talked through, and the differences reconciled, and action is taken.

I appreciate, in light of that long history that we have had, that you have come today to share your thoughts, as well as everyone else.

We have staff members seated at a table out here to do two things as we finish here today. Anyone who wants to make a statement today that we will incorporate in the record, we will take down with a staff member.

And I have summaries of the bill—we have about 300 copies here—that will summarize the elements of the bill, that will cover many of the things that have been talked about today.

I would like you to take one, take a look at it. If you have reactions after today, it is my wish that you would communicate those to me. Send them to me. If you have a statement that you want to make after today to be included in this committee record, I will include it in the record and we will take account of it.

I want to be able, in an orderly fashion, to be able to take any comments that anybody wishes to make and have as a part of this official record. Also, I intend to stay and to talk informally here for a bit with anyone who wants to come down and talk informally about the issues that have been raised, or to say things that they would just as soon say personally and not put in a statement that will go into the committee record.

So, with that, I want to thank our witnesses again today for the extraordinary effort that they have made to be here. I want to thank everyone else who was in attendance. I particularly want to thank Michigan State for its hospitality in letting us be here today.

And the committee stands in recess.

[Whereupon, the hearing was concluded at 1:10 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF DUANE ANGER

My name is Duane Anger and I'm from Shelby Township, Michigan. My wife Valerie and I have three children, ages fourteen (twins) and six. I am glad for this opportunity to testify to the health insurance concerns and problems of those who are unemployed.

For seventeen years I worked at Hoover Tool & Die, Inc., of Warren, Michigan. Hoover manufactured tools and dies for use in the automotive industry. I started there as an apprentice, moved on to become a journeyman and machine repair/rebuilder, and eventually was in charge of all repairs of precision equipment. It was a good job. I was also actively involved with UAW Local Union 155, serving as apprentice coordinator and then contract negotiator. When I first started at Hoover, we had 100 employees. The 1970's brought some bad times, and of course the 1980's were real bad on our industry due to foreign competition. As a result, company employment declined. In January 1990 we went down to 40 employees, and in January 1991 we went down to 12 employees. Our profits were cut due to the recession; there was less work available and higher competition.

Also cutting into the profitability of the company was the high cost of health insurance. We liked the plan we had because the coverage was good, including almost everything. But it was very costly to the company. In fact, other than the recession itself, insurance cost was one of the company's major financial downfalls. When you have 40 employees trying to make a profit to cover those 40 employees, plus office personnel, plus anywhere from 50 to 60 retirees, it was almost impossible. The company cost was astronomical. They offered HMO's which started out at a relatively low premium. But over time they jumped up as high as regular Blue Cross Blue Shield coverage.

I was laid off on May 7th of this year. The company closed and is not expected to reopen. In my particular case as a union member, my health insurance continued for 3 months starting the day after I was laid off. Those three months have just passed. Now, under the COBRA law, I can remain covered by the company plan for 18 months—but I have to pick up the premium cost. Just last Thursday I mailed my first check to keep my health coverage going. For a family of four or more, like mine, the cost is $372 per month. I hope to be working before the 18 months run out. If not, I will then have to pay over $500 per month to continue my family's coverage. I also have to think about my unemployment insurance. Once the 26 weeks of unemployment insurance is used—and it goes quickly in a recession—I'll need to think about health insurance costs, house payments, getting food on the table and all those other daily and necessary expenses.

I am well aware that there are many uninsured and underinsured people right now who face more dire circumstances than me or some of my colleagues. But that doesn't make the fear of losing health insurance or not being able to afford coverage any less real for us. The other day my daughter was running a high fever, and my wife and I hesitated to take her to the doctor. You hesitate because it's $55.00 just to go to the doctor. When you have to pay those expenses out of your pocket, you think twice. I've had cases where less fortunate younger guys don't take their kids to the doctor unless it's a life threatening situation—which is hard to tell sometimes. I've got one worker who was only making $7.00 an hour. With a family of four, now unemployed and not a lot of money coming in, how can he afford $372 a month? His wife is looking for a job that offers insurance benefits so they can ensure that the kids will be covered.

Like others who are concerned about the high cost of health insurance, unemployed people are afraid to let their insurance lapse. But, for some it is not a choice—they just cannot afford it. Folks don't want to leave themselves and their family uncovered but they see no other way. Some even talk about going on welfare or other public assistance programs just to get coverage for their kids.

After high school I attended college for two years. In the 19 years I've worked since then, the most humiliating experience I've had was going to sign up for unemployment. I had never been laid off before, and I got the feeling the people at the unemployment office thought that I was lazy or didn't want a job. This isn't true whatsoever. Most of the people that worked with me are out there every day looking for something. They are applying for jobs that do not even pertain to their skills. They are applying for menial jobs—just to have something—because the number one word out of everybody's mouth is "I have to make money to pay my insurance." Keeping health insurance going is probably the number one concern of Hoover's laid off workers. More of a concern than making a house payment—especially for those of us with children.

Since being laid off, I've kept in close contact with the guys I worked with. If I hear of something that matches their skills, I let them know. The trouble is that when you have skilled tradesmen who have become very skilled at what they do, there is a tendency to hesitate to hire someone who once made $19.00 per hour—even though we would work for less. As a union contract negotiator for 8 years, I can tell you that the number one issue on our mind for each negotiation was health insurance coverage. Our guys will take anything just to preserve their insurance. All 40 I've worked with have been actively seeking employment, hoping, among other things, to preserve affordable health insurance.

I understand there are almost 40 million people in our country without health insurance. Unless something is done, that figure is going to get a lot higher. When negotiating contracts a lot of companies will try to lower their health care costs. Sometimes, companies will choose to hire part time rather than full time so they don't have to pay health benefits. This just isn't right.

Nobody wants to be unemployed. When you lose your job unexpectedly like we did, it is quite a shock. There's no place for a lot of people to turn. If they can't get a job right away, they have to somehow find the means to get their insurance or let it go.

Because of the recession, I lost my job. I'm collecting unemployment insurance and hope to become employed before it runs out. As a union member I am thankful that I can continue health benefits for my family and I even though I'm not sure how long we can afford to pay the high cost of the premiums. I am willing to do whatever I need to do to find work. While my job search continues, I don't want the additional burden of losing my health care insurance or not being able to provide health protection for my family. I am glad, Senator Riegle, that your bill contains provisions that would allow the unemployed to access health insurance coverage based on ability to pay. This is an important provision that will address a very real and growing problem.

I think we have to have some type of bill like "Health America." It is sad to know that while we're floating billions of dollars to other countries, almost 40 million of our own live without health insurance. I am an average American who has worked hard to provide a decent life for my family. I don't want my temporary employment crisis to put my family's health in jeopardy. If you were me—and anyone could easily be in my situation—I know you would want the same for your family, too.

PREPARED STATEMENT OF DAVID W. BENFER

Thank you for the opportunity to comment on Senate Bill 1227 which expands access to health care by making basic health insurance coverage universally available to every American within 5 years. This proposal balances cost of expanded access with new savings to be gained from standardized benefits, and prices, global budgets, managed care; clinical guidelines, outcomes research and technology assessment. The Henry Ford Health System supports the comprehensive direction of this landmark legislation.

A national health policy on access and cost is long overdue. We are grateful for your work over the past several years, Senator Riegle, in moving the debate forward.

We commend you and your colleagues for stating a policy position that everyone in America has a right to health care coverage, and for setting forth a proposed roadmap in Senate Bill 1227 that describes a way to reach this objective.

A key contribution of this legislation is that it clarifies a policy position on *financing* of health services:

1. Responsibility for employed persons and dependents, together with the economically self-sufficient, is assigned to the *private sector.* This is what the "play or pay" requirement for employers means.
2. Secondly, responsibility for the aged is assigned to Medicare.
3. Responsibility for all others is assigned to AmeriCare, which is an expansion of Medicaid to include coverage of low income persons.

Such a comprehensive financing policy is necessary to achieve universal coverage.

You have asked us to comment on some of the problems in our urban service area that this legislation will address, as well as provide suggestions for ways to strengthen the bill.

Our written statement that has been submitted for the record covers suggested changes for the legislation. What we have asked for are new provisions in the bill that will encourage the growth and development of managed care capability in the delivery system. In addition, we recommend specific recognition in the bill of basic differences between managed care health plans that are funded by per capita payments and those that are financed by fee-for-service payments.

Today, I will highlight the problems that will find solutions In the universal access guarantees of Senate bill 1227.

The perspective of Henry Ford Health System is one of a large regional health care organization that serves a diverse urban population in Southeast Michigan and derives approximately 38% of its total revenues through capitation arrangements with our own HMO (Health Alliance Plan of Michigan).

The Henry Ford Health System is Michigan's sixth largest employer with more than 15,000 employees. The System includes 33 urban and sub urban outpatient centers, one short-term inpatient psychiatric hospital (89 licensed beds) and major research and medical educational programs.

Urban areas like the communities we serve in Detroit are subject to great stresses. Unemployment, Homelessness, Crime, Drug Abuse and inadequate funding for Education all take their toll on this community. These social problems are reflected in the needs of patients who present themselves for health care services. Senate Bill 1227 offers new hope and a much needed safety net for this community that Medicaid and the private sector can't assure.

During the 1991 Michigan State budget crisis, HFHS began tracking the impact of Medicaid reductions in Wayne County. Approximately 52% of all cuts in Michigan Medicaid funding come from the HFHS immediate service area in Detroit. Of the approximate $55 million targeted savings state-wide, a little over $29 million of the reductions fell on Wayne County. At the same time those health care reductions were announced, large reductions in income assistance were also implemented affecting approximately 40,000 people. Whatever the justification for these measures, economic reductions of this magnitude in a short period of time (less than 6 months) tears at the very fabric of the Detroit community.

Our Detroit urban catchment areas have chronic illness and infant mortality rates several times greater than the national average. Unemployment is high, incomes are low, and the people are relatively young with low levels of educational achievement.

The following are indicators that profile special needs for two of the inner city Henry Ford Health System communities:

	United States	Detroit (All zip codes)	Henry Ford Hospital (5 zip codes)	Samaritan Health Center (3 zip codes)
Total Population	250,000,000	1,099,799	206,483	136,402
Median Age	32.3 years	@30 years	@30 years	@30 years
Education less than 12 yrs	23.7%	46.1%	49.3%	49.3%
Income—Below FPL	13%	32.9%	43%	44.3%
Infant mortality (per 1,000)	10.0	20.5	20.8	26.4
Overall death rate (per 100,000)	882	1,183	1,579	1,509
Chronic Disease (per 100,000):				
Cirrhosis	9.0	31.0	49.2	39.2
Heart Dysfunction	166.3	317.5	564.4	609.5
Respiratory Cancer	39.9	54.1	101.6	76.9
Pneumonia/Influenza	14.2	29.0	44.0	52.3
Cerebrovascular Dysfunction	29.7	62.1	91.1	76.9

	United States	Detroit (All zip codes)	Henry Ford Hospital (5 zip codes)	Samaritan Health Center (3 zip codes)
Diabetes Mellitus	15.14	22.0	29.3	33.0
Unintentional death (per 100,000)	35.0	33.7	40.8	39.2
Homicide	9.0	61.7	97.4	69.2
Drug related	N/A	21.5	30.4	17.7

Often in our Detroit communities, we are in the position of providing emergency care and expensive hospital care when we would prefer providing *health* care. Lack of insurance and inadequate public funding results in limited primary care services for low income patients in many states, as documented in the recent Physician Payment Review Commission Report.

In Michigan, Medicaid underpayment and charity care caseloads have clearly restricted low income patient access to primary care and have undermined efforts of the legislature and the Department of Social Services to improve obstetrical and prenatal care. As a result of Medicaid underpayments to physicians and lack of insurance coverage, many urban hospitals have become a substitute "family doctor" in the urban communities we serve.

The Henry Ford Health System includes six 24-hour emergency facilities that have increasingly become the point of entry to the health care system for people without a primary care doctor or insurance coverage. Without access to primary care, many low income Patients present themselves in advanced stages of disease that could have been avoided. Current state and federal policy tends in guarantee emergency care (through Medicare "anti-dumping" rules, for example), but neglects primary and chronic care needs.

Senate Bill 1227 contains a dual strategy that will successfully address heath needs of low income urban areas. First, enrollment in AmeriCare will provide payment for everyone below 200% of poverty. In Wayne County, there arc approximately 385.000 Medicaid eligibles (⅓ of all Medicaid eligibles state-wide), 50,000 people below poverty who currently are covered by County Care, and another 250,000) people of various income levels who have no insurance. AmeriCare will provide an affordable opportunity to obtain coverage for this entire population of 685,000 people. AmeriCare means better health status for this community through new revenues and new access to needed services.

Secondly, the bill targets primary care access through Community Health Center expansion. Community clinics have proven to be a successful way to provide care in poor, urban settings where patients may lack transient or may lack transportation. In Detroit, public transportation gaps add to access barriers, so there is a special need here for local public health clinics close to home. We strongly support the recognition and funding Community Health Centers will receive under Senate Bill 1227. The City of Detroit operates several clinics that are currently overburdened, and additional facilities of this type are much needed, particularly during the five year phase-in period before AneriCare enrolls all low income uninsured persons in Wayne County. Because of the special needs of this population, you might also consider special support for home health outreach Services; as well as school based clinics.

As a system, HFHS financed $26 million in charity care end $19 million in underpayment from Medicaid in 1990. This cost is particularly heavy at our urban facilities, where losses due to uncompensated care must be balanced by positive margin elsewhere in the system. The financing of care to the uninsured by shifting costs to other payors has become difficult. Currently, approximately 90 percent of our revenue base is unavailable for cost-shifting due to fixed payment arrangements with HMOs, Blue Cross and government payors. Continued cuts in Medicaid and Medicare reimbursement and eligibility restrictions make Problems worse.

Medicaid payment ratios for HFHS arc about 55% of *cost* for outpatient services, and 41% for physician services. The Henry Ford Health System Medicaid losses for outpatient and physician services alone were more than $12 million last year. In addition, HFHS is picking up more charity care costs when benefits and eligibility for state funded programs are reduced, because this organization must continue to serve the population adversely affected. For some providers in Michigan, the erosion of employer coverage has also created new bad debt, because minimum wage workers can't meet deductible and copayment obligations.

Universal access means that the urban hospitals and physicians will no longer bear a disproportionate burden for uncompensated care. Under Senate Bill 1227,

Medicare payment rules for hospital and physician payment will be the new standard for both public and private payors. With the parity of payment rule in Senate Bill 1227, underpayments by the public programs will disappear.

Parity in payment solves the uneven distribution of charity care costs problem, but it also opens new opportunities for better health status. Expanded access to primary care services means earlier interventions in chronic disease and lower costs for emergency care. In many ways, Senator Riegle, the new access to primary care represents one of the most important cost-savings elements of this legislation for areas like Detroit.

The best example I can offer has to do with what low birth weight babies mean to society and the health care system in terms of quality of life and costs. Recent studies of the success in the U.S. at reducing infant mortality rates document that little progress has been made with improving birth weights. Birth weight is the best indicator for long term health of the infant, and is directly related to good prenatal care. Without good prenatal care, we tend to see very small babies delivered prematurely and requiring intensive medical care for long periods of time. Census in our neonatal intensive care unit at Henry Ford Hospital and other hospitals in Detroit is higher than the rest of the state. Better primary care before the birth will lower this cost.

The latter sections of the legislation spell out managed care as a preferred strategy under AmeriCare. These sections constitute a critical strength of the bill. By establishing managed care as federal and state health policy, the legislation helps untangle problems many states encounter in trying to obtain waivers that allow Medicaid agencies to promote enrollment of patients in managed care plans. The proposed financial incentives through the enhanced payment rates for states that achieve a high percentage of AmeriCare enrollment in managed care plans is an effective way to implement this policy. We support the policy direction and commend you for an important contribution to cost-effective, high quality care for low income patients.

Managed care is the uniquely U.S. contribution to health care. Ways to encourage the growth and development of this built-in U.S. strength should be a high priority. By focusing on the patient, rather than the service, managed care offers real opportunities to not only save money, but also to assign responsibility to local health providers for cost-effective health care in a designated geographic area, like urban Detroit, or for a defined population, like children or seniors covered by Medicare.

To the extent that managed care occurs today, it is an achievement of physicians and hospitals, not insurance companies or other third-party payors. Insurance mechanisms provide critical incentives (or disincentives) for the delivery system to respond with managed care. But the requisite integration of services, with an emphasis on prevention and primary care, cannot develop without decisions and actions by providers to address the needs of patients through a managed care delivery system.

You may want to consider amendments to Senate Bill 1227 that encourages federal and state governments to inventory regulatory barriers that inhibit growth of managed care and regional systems, such as anti-trust laws and fee-for-service payment practices, and set a timetable for addressing these barriers. Otherwise, managed care as a national cost-containment strategy may fall short of the savings needed to pay for expanded access.

HFHS supports universal coverage and the extension of tax benefits to small business.

We support the policy on fairness with regard to maximum out-of-pocket expenses. Under Senate Bill 1227, out-of-pocket expenses would be governed by the ability to pay, with very low income people paying very little and higher income people paying a maximum percentage of premium cost. This policy helps minimum wage workers and makes the overall financing approach more progressive.

The goal of fixing the major current insurance-based problems that exclude people, by phasing out insurance underwriting (exclusions and limitations) for all health coverage plans and a return to community rating, is a most welcome policy direction.

Malpractice liability remains a substantial burden for health care, even with universal access. There is great potential for savings in Michigan, where the malpractice costs are several times the national average. Temporary, partial and permanent closure of emergency rooms throughout Detroit creates a domino effect on remaining facilities, including HFHS hospitals. Liability constitutes a serious deterrent for adequate coverage of HFHS suburban hospitals that must rely on community physicians not salaried by HFHS. Direct and immediate action is needed to address overall costs and the dangerous service disruptions that liability creates for emergency and obstetrical care.

It is unclear how medical education and medical research will be supported under the legislation. These are sensitive areas necessary to maintain high standards for quality of care. Current funding for these areas is integrated with regular payment mechanisms. Any shift away from integrated funding to segregated funding for education and research may be difficult. The transition period merits special attention for vulnerable urban institutions like Henry Ford Hospital with sizable responsibilities for medical education, research and service to low income patients.

PREPARED STATEMENT OF JOHN E. BOND

Good morning Senator Riegle. Thank you for this opportunity to address you on behalf of the International Brotherhood of Electrical Workers Local 948. My name is John Bond. I am the Business Manager with Local 948 in Flint, Michigan.

I would like to address some of the many problems with health care in our country, the cost of having proper health coverage, and respond to the cost containment provisions in HealthAmerica. Cost containment of health care is the most important single issue facing our country today and is one of the overriding issues in almost all labor negotiations today. If something is not done to control the rising cost of health coverage and provide the necessary treatment for those in need, I believe millions of Americans will continue to suffer.

I belong to a health plan here in Michigan that covers over two thousand participants. At the present time, I am a Trustee in this plan and also the Chairman. We cover all the Union Electricians in the Upper Peninsula and all but those in the Detroit, Ann Arbor, and Saginaw areas down state. Our problems vary because of the large geographical area that we cover, but we all have one common problem. That is the rising cost of health care. From the smallest town in the Upper Peninsula to Flint, the concerns of health coverage are the same. If something is not done to stop the rising cost, it will be just a matter of time that no one will have insurance, and if they do, the coverage will be so small that it will not be worth having a plan.

In the past few years the cost of our insurance has risen 41% for our active members and 114% for retirees. While these costs have gone up, our benefits have remained the same. This means that more of our dollars are going toward health coverage and less for educating our children, and providing needed things for our families. Every time the cost of medical bills go up, there are thousands of parents that are unable to buy something that is needed for their families.

Six months ago our health plan was told by our actuary that we were going broke. He told us that, if we did not make some major changes within the next two years, we would be out of business. We decided to add thirty cents per hour per member to offset this difference. Three months later we were told that this was not enough and more changes would have to occur. It was recommended by a committee of trustees that we have all self payers pay more into our plan, to keep their insurance. This recommendation was approved. Yet still today, there are concerns that we may have to either add more money or reduce benefits. These are thing that are not only happening to our plan, but are happening all over Michigan.

The retirees in Michigan may be the ones most dramatically impacted by the cost of health care. They are caught in a catch 22. They are the ones who can least afford to pay for it. The retirees in our plan have had their insurance go up over 100% in a three month period. In May of 1991, we had retirees paying $64 dollars per month. In October of this year they will be paying $136 dollars per month. For retirees that were over the age of 65, the union paid for their portion of the supplement to Medicare. Today we can no longer afford to do so. These retirees must pay $19 dollars per month for themselves and an additional $19 dollars per month for their spouse. These increases that our retired members are having to pay are very difficult. They are on fixed incomes. They do not have anyone or any place to turn for help. They are at the mercy of the health plan and that plan is going broke.

One of the main reasons for the increases in premium costs that the Union has witnessed is the cost-shift factor. The uncompensated care problem that is prevalent in the nation is a cost for us all. In effect, we are paying a hidden-tax in our premiums and in the cost of medical services. Insurers and providers have to some way recoup the losses that they incur for uncompensated care. Therefore, they shift the costs to groups and unions like ours who have private insurance. With HealthAmerica the current cost-shift problem would be alleviated as everyone would have access to the basic health insurance plan called AmeriCare.

Another important cost-containment measure in HealthAmerica is the Federal Health Care Expenditure Board. I understand that the function of this board is to

bring together the purchasers of care and the providers of care to negotiate and establish fair rates for health services. This is similar to what happens now in labor negotiations and we have found this to be an effective way of attaining solutions to similar issues in the labor/big business arena. Other cost containment provisions in HealthAmerica such as those which will reduce unnecessary care and administrative costs should have the effect of downsizing our overall health costs as well.

Another serious problem we are facing today is trying to continue health coverage for our unemployed brothers. Many of our members have exhausted all of their unemployment benefits, and can no longer afford to make self payments to pay for their health insurance. HealthAmerica recognizes this. AmeriCare would be available to all those who don't have health insurance through their employer. Unemployed people whose benefits have expired wouldn't have to fear being uninsured. They could get basic, solid health benefits through AmeriCare until new work was obtained. This feature of AmeriCare is important because it will act as a safety net for our members, and our nations unemployed. If people who have coverage today, lose that coverage, then the State and Federal Government also lose because of tax dollars will have to be used to take care of these people needs through various public assistance programs.

It seems to me that we live in a sorry state when a person has to choose between putting food on the table or providing health coverage for his family. This may seem drastic but in some cases this is very true. There are many families in our health plan that cannot afford to do both.

Retirees are going without things that they need and so are the youth of this country. For a young person to go out and buy insurance today is almost impossible. The cost is unbelievable, and the job opportunities that provide insurance are almost impossible to find. The rising costs have not only affected the retirees, unemployed, and the youth of this country, but every hard working American in this country. Each day employers and employees are becoming more and more concerned about how they can maintain health coverage. The working people of the country can no longer expect the employer to provide health insurance in light of the skyrocketing costs. The employers find it difficult to pass on the costs to the employee but they have little choice. They also past it on to the consumer in higher prices for products and services. Businesses are finding it more difficult to pass these costs on and still be competitive in the market place. More and more Americans are finding what little bit of a raise they are able to negotiate at the bargaining table is being eaten up by health costs. Improved benefits that have been gained through collective bargaining, increases that have been implemented in Social Security and the raise in the minimum wage, have been eaten away by the rising cost of health care.

This country needs a cost containment plan, and it needs it now. HealthAmerica is the right step. I am glad, Senator Riegle, that you and your colleagues have said enough is enough and are working to stop this outrageous cost today. Men and women of this country should not have to live in fear of becoming ill or wondering what is going to happen to their families. Children should be born with the best possible medical attention available, and we should all die knowing that everything that medically could be done was done. It is time we took care of all Americans in America.

PREPARED STATEMENT OF KIM CAMERON

My name is Kim Cameron. I'm 26 years old and I have had Crohn's Disease for five years. As some of you may know, another young woman with Crohn's Disease testified before Senator Riegle in June of 1989. Cheryl Eichler died six months after that testimony. When I read about her story and Senator Riegle's Health America bill, I knew that I had to call Senator Riegle about my story. I contacted his office in July of this year and told him that I was exactly like Cheryl Eichler. That is how I came to be before you today. Help came too late for Cheryl, I won't let that happen to me.

Five years ago I began having symptoms of Crohn's. At the time, however, I was diagnosed with Colitis. Colitis is similar to Crohn's, but only affects the colon, where Crohn's affects the entire digestive tract. During this time, I had insurance through an employer group plan. However, due to cancer from another group member, the insurance company told the group that our premiums would have to be raised, because we were now at a higher risk. The members of the group figured that they could get better insurance at a lower cost privately and the group dropped the plan. I immediately went to the same company that I had been covered by for three years

and was denied coverage. I was told that now I had become too much of a risk. Since that time, I have been uninsured. I went to every insurance company and every HMO for coverage. I was denied at every one due to my disease. I went to Blue Cross as my last chance. I was told they would cover me, for $167 a month, $2,000 deductible, a six month waiting period, no prescription coverage, and an 80/20 payment plan. How can they do that? There is no way I can afford that. They charge people outrageous amounts because they're sick. That's not right. It's unfair. People talk about preventive care. If you know you have a disease, preventive care is easier, but no one will cover you. Someone who appears healthy can be covered, but they could have a worse disease pop up tomorrow. All I can say is once you get coverage, hang onto it with everything you've got.

Last fall, after my doctor determined I had Crohn's, not Colitis, I was supposed to be seeing him every 2-3 weeks. I didn't go because I had no way to pay. I moved to Indiana to look for work but found no one would hire me once they found out about the Crohn's. I developed blockage in my small intestine and every meal I ate came back up. I was getting weaker and weaker. In March my mother was scheduled for back surgery. I wanted to come back to Michigan for her, but was so sick my aunt had to drive me. My mother insisted that I go to the doctor. When my doctor saw me, he told me to meet him in emergency. I told him I couldn't pay, and he said his fees didn't matter, but he had to get me well. I had lost 60 pounds in four months and was feeling really awful. At this time, I was put on steroids, and pumped full of nutrition. I had literally feet, not inches, of intestinal track that was inflamed. The steroids helped, but this summer some of the damaged area had to be removed. My doctor told me in July that if I didn't get myself admitted and operated on, I would only have a month left. If I had been medicated before, I wouldn't have gotten that bad. But I couldn't pay for it. That makes me so mad! Three weeks ago, I got out of the hospital after a two-week stay where surgeons removed part of my colon, eight inches of my small intestine, my appendix, and my gall bladder. I cannot pay for this care. When the hospital tells me I have to pay, I tell them that I can't pay until I can work and I can't work until I get well. Get me well and I can pay. I asked the hospital to give me a job and they could garnish my wages, but they wouldn't do that either. It drives me nuts that I can't work! I started working part-time at age 14 and full-time by the time I was 17. And now no one will help me? I have tried to help myself, but that only goes so far. My dad could get me on his Blue Cross through GM, but only after a 6-month waiting period because of my pre-existing condition, his taking full financial responsibility for me including my back bills, and $100 a *week* premium. I won't let my parents do that. They are not wealthy people. I will not let them lose what they have worked so hard for. They are getting older, but I have a lifetime of wages to garnish ahead of me.

I have applied for Medicaid twice. The first time I was denied because I made too much money—$4.00 an hour. The second time I was denied because I was over 21, under 65, not blind, not pregnant, and had no dependents. I have also been denied Social Security Disability. Senator Riegle's bill would help me. I could get the coverage I need. Crohn's is a treatable disease if you can pay for it.

I support *HealthAmerica*. Senator, you have asked the people of Michigan for their comments about the bill. I particularly like the provision in your bill that requires insurers to cover all people regardless of whether they have a pre-existing condition. Also, the improved rating structure that would spread the risk over more people would make premiums more affordable to me. I see that the bill covers pregnant women and children first. While I agree that this is important, if I had been pregnant I would have been covered. I think it is also important to cover the people who are sick and may be running out of time.

I am not asking for something that I don't deserve. Every American deserves quality health care. *HealthAmerica* would see that they get it. Thank you for allowing me to testify today.

PREPARED STATEMENT OF DAN CHAMPNEY

Good morning Senator Riegle and other distinguished guests. My name is Dan Champney and I am Vice President and General Counsel of Healthplus of Michigan. It is an honor to have the opportunity to comment upon Senate Bill 1227—The HealthAmerica Program. The health care delivery system in this country and in the State of Michigan is itself in poor health. Just about anyone who does an analysis of other industrialized countries and compares what we get for what we spend reaches the same conclusion. Few who have noted the bleak comparisons have suggested

reasonable solutions. For that reason alone, Senator Riegle you, as well as Senator Mitchell, Kennedy, and Rockefeller and their staffs, are to be congratulated.

There will be two parts to my testimony this morning. First, I would like to share some of the history and experience of the company that I represent, Healthplus of Michigan. Secondly, I would like to offer some comments relative to the role of managed care in the HealthAmerica package. I am also sharing my time this morning with Dr. VanDuyne who will comment upon the HealthAmerica proposal from the perspective of a physician operating within & managed care program.

HealthPlus of Michigan is a federally-qualified and state-licensed health maintenance organization. As an HMO, Healthplus arranges through contracts with physicians in independent practice (and other health care providers) to provide specific benefits to our members in exchange for prepayment from enrolled groups.

Like many other HMO's around the country, HealthPlus has not been operational for that long. We enrolled our first member in the fall of 1979 and now have grown to over 100,000 enrollees.

In addition, through two subsidiary corporations, Healthplus also now offers non-HMO type benefits such as self-insured program and low cost insured options. We continue to try to develop new products to meet what is a very rapidly changing health care landscape. Common to all of our products, however, is the concept of "managed care."

While Healthplus has its roots in Flint, Michigan, it has now expanded to encompass a service area from Bay County down through Monroe' County and, consequently, provides health care coverage along the "I-75 corridor" a geographical location with very unique health care characteristics.

As Dr. VanDuyne can testify, HealthPlus was founded through a very broad community task group in order to foster competition in the delivery of health care in the Flint market. This task group had representatives from the medical community, employer groups, and organized labor. They saw a need and played a very key role in the establishment of a managed care entity which could bring some order, control and efficiency to the delivery of health care. We believe that these original goals have been met.

Over the past twelve years HealthPlus has acted as a catalyst for change in the way that health care is delivered in the Flint and Saginaw communities.

Some of the more direct consequences of our actions in this service area are:

1. Utilization of appropriate care settings.
   Since its initial operation, Healthplus has seen a reduction in active inpatient use rate of greater than 60%. This has been a result of a focus upon the appropriate setting for necessary care. The appropriate setting for the rendering of necessary care is not necessarily an acute inpatient hospital setting, but rather may be an extended care facility, skilled nursing facility, or even perhaps the patient: own home.
2. Negotiated managed care contracts with providers.
   Healthplus has been able to negotiate tough managed care contracts with health care providers. The contracts not only provide for meaningful discounts, and the exercise of a variety of managed care techniques, but also involve the provider of care very directly in providing care in an efficient means. In addition, by its very nature, the negotiation of a provider contract involves a selection process by which a preferred panel is derived. With the concept of a selected panel comes the advantage of better management for the delivery of care.
3. Assimilation and use of a credible data base.
   Because of the controls and contractual basis behind the business, Healthplus has been able to implement and maintain a credible data base. Trying to make any progress in the delivery of health care without credible data is an exercise in futility.

Beyond these very specific affects that Healthplus has had in its service area, there are a variety of indirect benefits. For example, if a physician is made aware of the relative cost of different pharmaceutical products with equivalent efficiencies, the practice pattern toward the more efficient drug may be adopted by that physician whether or not a managed care patient is involved. The same could be true concerning the selection of specialty care or the availability of other community Services to help the patient.

Having now spoke for several minutes concerning the HMO industry in general and Healthplus specifically, let me devote the remainder of my time to focusing upon HealthAmerica.

We are very pleased with the Predominant role that managed care, both as an industry and as a way of doing business, has in this legislation. Managed care has

the best chance of simultaneously considering the cost/quality and availability of health care to Americans. Some have suggested that cost and quality are on the opposite ends of the health care delivery spectrum. This is simply not true. More care and expensive care is certainly not necessarily better care. Over utilization can be as damaging to a patient as under utilization. Managed care focuses upon the right care in the right setting with the right result.

The delivery of health care, like any other industry, must be looked at critically and analytically, utilizing the best possible data available to make knowledgeable (certainly difficult) decisions. Managed care entities have the best potential for doing this since by their very nature they involve the essential players, i.e. the purchaser, the provider, the patient, and the administrator.

We are similarly very pleased in the structure of the Act which, from our reading, allows the natural competitiveness of health care delivery to play a significant role under the program. It would certainly be a significant mistake if the experience gained by managed care entities around the country were lost through any type of national legislative mandate for a single payor administrative structure. Once again, our reading of this legislation would lead us to conclude that a single payor system is not being advocated.

Next, HealthPlus believes that the HealthAmerica Act would have had greater potential for having a positive impact in the State of Michigan with a more active challenge to the problem of medical malpractice. In the State of Michigan the managed care movement and the medical malpractice movement seem to be on a collision course. I do not believe that there is a single physician either participating with Healthplus or practicing in Southeastern Michigan that does not sense an enormous rain cloud over their shoulder as they practice in a managed care setting.

In conclusion, HealthPlus believes that the HealthAmerica Act is a bold initiative founded on sound and correct principles launched the hope of bringing some order and control to the health care system to this country. We look forward to working with you, Senator Riegle and others, toward meaningful solutions in this area.

Thank you very much for the opportunity to express our views. I would now like to give the remainder of my time to Dr. VanDuyne.

PREPARED STATEMENT OF HOWARD JOHNSON

Herman Miller is an international organization with over 6,000 employees.

It is committed to providing health care coverage for both its employees and their dependents. This commitment has been in place for over 40 years.

It is also committed to providing health care protection for all of its retirees and their dependents who have completed at least 10 years of full-time service with the company.

Herman Miller is committed to support the extended family as well, providing pregnancy coverage for single, dependent children of employees. Continuing health care coverage is provided not only through COBRA coverage but also through offering continuing coverage to surviving spouses of all employees and retirees who pass away after age 55.

Concern is shown for employees and members of their families who have pre-existing health conditions at the time of their employment by providing immediate coverage for those pre-existing health conditions.

The company is basically self-insured in the health care area, being at-risk for the first $200,000 medical expense in each year for each employee or dependent participant, with a $1,00,000 lifetime per-person limit.

The average gross cost per employee for providing health care and life insurance at Herman Miller is now $3,500 per year. The cost is rising at the rate of over 10 percent per year and is a major concern to the company. Constantly rising costs are eroding the company's profitability margin and limits its ability to grant wage increases and benefit improvements.

As a result, the company has had to shift more cost to the employees and has emphasized managed care through Health Maintenance Organizations and tried to direct a portion of the business to a Preferred Provider Network. Currently over 50 percent of company employees are enrolled in HMOs.

We support and encourage the efforts that are being made by the federal government to provide comprehensive health care reform, including cost containment and universal access to health care.

With respect to the specific health plan Americare, we are supportive of many concepts in the proposed bill. These include:

- Broadening access to health care coverage to many more Americans.

- Providing that access by way of the employers.
- The basic benefit package and cost sharing concept.
- Reducing cost shifting to private sector payors.
- Emphasizing managed care.
- Providing coverage to part-time employees.
- Addressing medical malpractice liability reform.
- Establishing standardized claims and billing forms.
- Pre-emption of state mandated benefit laws.
- Expanded use of practice guidelines and expanded outcomes research and technology assessment.
- Providing coverage for pre-existing medical conditions.
- Restructuring and expanding publicly funded insurance for lower income persons.

The concerns that we have with the proposed legislation are as follows:

- The size and source of public funding required to implement and operate the plan.
- The possibility of special interest medical groups influencing the design of the plan to insert coverage which goes beyond basic health care.
- The possible complexity of administrative rules and paperwork which will be imposed on employers.

We do believe that the proposed legislation provides an excellent opportunity for constructive dialogue on an important topic. We appreciate the opportunity to comment publicly on it.

PREPARED STATEMENT OF PEARL LIPNER

I would like to thank Senator Riegle and the committee for asking me to be a part of this hearing and the process of exploring HEALTHAMERICA.

Image Express edits television commercials. We are a very small cog in a very large industry. However, like many other niche-inhabiting companies, the work that we do is quite esoteric and requires formidable skills. It is, therefore, necessary for us to pay high wages and offer a substantial benefit package to our employees. These number 21 full-time permanent; and, because our work is seasonal, up to 10 more temporary who are employed as part-time and/or independent contractors for several months a year. Annual salaries range from $16,000 to over $100,000, and totalled $1.2 million in 1990. Our monthly health care premiums are $146.00 for single coverage and $458.00 for an employee with dependents. Not counting the health-care portion of FICA, executive life and disability premiums, or the administrative expenses of our Section 125 flexible benefit package, our at-risk cost for employee insurance was $100,000 for that year. As a percentage of salary these costs range from 23% for lesser compensated employees to 6% for the most highly paid, with an average of 8.3% overall.

We started this business in October, 1978, and have had continuous coverage since the first year. It has taken many and varied forms. And has never, in nearly 13 years, been easy to deal with. There have been times that I could track a loss on our balance sheet directly to premium payments. In a closely-held corporation this decrease in owner equity can certainly give one cause to reflect on the order of magnitude of responsibility to one's employees. Particularly for a benefit that is available as a private-pay purchase. Certainly as the economy, in general, continues to droop, and advertising, in particular, tightens its belt, the cost-cutting imperatives could seem to outweigh the previously sacrosanct package offered by my company. In the last three years we have had our premium costs raised by 42%, 13% and 6%, which is a cumulative increase of almost 71%. (And, been told by our agent that we have been lucky because these increases have been lower than those of many businesses in our market.) Needless to say, since inflation has done nothing to deflect this leap, this erosion of our margin makes quite a difference to our bottom line. For as vendors to the automotive industry, we have not been able to raise our pricing to reflect this increase.

The average age of our staff is 32, and we have suffered only one catastrophic illness, which lasted 6 days, in almost 13 years. This is not a high-risk group, nor is there very much abuse of benefits. Given those factors, and the unhealthy state of the economy, the subject of insurance becomes more sensitive each time we have to determine budget. Although it has always been important to the company to provide total medical protection, and we certainly want to maintain the standard we have set, it would be fiscally irresponsible to ignore the obvious. In the event of the

need for a budget cut, the deletion of this coverage could, if necessary, mean the preservation of 5 jobs. That is almost 25% of our current work force. If faced with the choice of insurance benefits or a job, you can't ask people to draw straws to see who is going to leave for the good of their coworkers.

With that in mind, I would like to turn my remarks to the proposed HEALTHAMERICA bill. It has always been the case that the philosophy of Image Express leaned toward the welfare of its workers. The corporate policy was to try and eliminate any distractions to an employee's productivity caused by concerns that we could lessen. Complete health and medical coverage is one of the ways of accomplishing that goal. It is much easier to devote your attention to your job if you know your Dr. bills, or those of your family, are covered and you don't have to worry about where the money will come from to pay for them.

On the face of it, this bill could eliminate that concern for millions of people, and enable greater participation in the daily work effort of this country. Since my portfolio is small business, that is the only portion of this bill that I will be addressing. I am outlining my responses to the summary, in order of the summary. I wear several hats in this situation:

1. as a business owner in a much more cost-conscious economy;
2. as the administrator of a qualified flexible benefit plan normally offered by much larger companies;
3. as a believer in basic health services for all people;
4. and, as a small business association board member that has seen what a proliferation of new laws, regulations and government divisiveness have done, over the past 8 to 10 years, to discourage privately-held business owners from having as much faith in government programs as might be appropriate.

Therefore, my thoughts may sometimes be at odds with each other. I hope that you will bear with me.

There are some pleasant surprises in HealthAmerica, to whit:

—individual responsibility for some of the costs
—preventative health benefits, which are often not covered by even the most expensive private policies
—recognizing the need for health care for low-income non-aid dependent employees, and their families
—pre-existing condition limitations on coverage
—an improved delivery system
—the reduction of unnecessary or ineffective care
—the elimination of unnecessary administrative costs; particularly a standardization of claims forms and the use of high-tech systems to minimize paperwork
—small business insurance reform
—the development of cost and quality data on individual providers, as long as it is more than just a computer game played by a bureaucratic agency used to self-perpetuate a body of redundant information
—improved tax treatment for the self-employed is long overdue

One of the most encouraging aspects of this proposal is the provision for tort reform and investigation of the malpractice problem in this country. It is significant that this issue is part of a package that promotes primary care services in underserved areas. One of the main reasons that we have seen a lessening of services in the 7th largest city in the US is the astronomical cost of malpractice insurance in Wayne County. It has become almost virtually impossible for an independent Dr. to practice medicine in the city of Detroit. This is a travesty.

In recognizing that there will be revisions to this Bill, I would hope that the following concerns will receive thorough consideration.

STATES WILL BE GIVEN THE OPTION TO REQUIRE THOSE EMPLOYERS WHO ELECT TO MAKE A CONTRIBUTION TO THE PUBLIC PROGRAM TO COLLECT THE EMPLOYEE'S PORTION OF THE PREMIUM. IN THE ABSENCE OF THIS REQUIREMENT, EMPLOYERS WILL BE ALLOWED TO VOLUNTARILY COLLECT PREMIUMS ON BEHALF OF EMPLOYEES.

I don't know which part of this statement I resent more. In essence, we again become the collecting agent for a taxing authority. Right now it is mandated that an employer, of any size, has the responsibility of collecting and distributing to the appropriate funds FICA, Federal, State and any other local income tax that an *employee has an obligation to pay.* There is nothing voluntary about the deduction, collection and/or distribution of any of the aforesaid moneys by an employer. And to state that we would " . . . be allowed to voluntarily collect . . . " really pushes the

point. In California, where my company has an office, we are already responsible to 5 different taxing authorities, with 5 different reporting procedures, at 5 different points in time. This plan would add a sixth deduction to keep track of and be accountable for. Besides putting the employer in the role of being an unpaid revenue agent, it creates an animosity with the employee who sees me as the reason that their check does not reflect the wage that they believe they are being paid. I understand the savings to government that this service provides. This might be the time to ponder what consideration these agencies might offer in return.

By setting 17½ hours as indication of full-time employment, I fear that students will no longer be able to find after-school jobs because it will be too much of a problem to go through the paperwork necessary to certify their exemption because of eligibility under a parent's plan. It also makes a number of employers responsible for workers that may have previously been covered by Medicaid under some type of government or industry sponsored training program. This becomes unfair to the employer without added incentives to hire these people. Although I stated that I would only be addressing the business portion of this plan, I cannot help but comment on some of the aspects of the public plan. Since this is a Federal-State program, created to extend basic medical services to all people equally, it seems strange that there is a State's Rights provision to determine optional services. Does this mean that some states will be able to continue to exclude certain legal medical services available in other states? Does it mean that some states will be able to triage care, as is now the case, that doesn't fall under the basic plan?

DURING THE FIRST FIVE YEARS AFTER ENACTMENT, SMALL BUSINESSES THAT HAVE NOT PROVIDED COVERAGE TO THEIR EMPLOYEES DURING THE YEAR PRIOR TO ENACTMENT OF THE LEGISLATION WILL BE ALLOWED TO BUY INSURANCE. . . . AT A LOWER COST.

I currently spend $100,000 a year more than my closest competitor by offering a good health care package. This is my decision to make as a business owner. However, this provision "unevens the playing field" by government intervention, and has my taxes paying for my competition's ability to take into account this cost advantage while bidding for a job against me.

To end my litany against specific provisions of the bill, I would like to state my concern for the use of a $53,000 figure to establish a "high profit firm." I believe that although the intention is valiant, the criteria used falls short of the mark needed to give relief to the targeted businesses.

I have yet to address the main concern of small business with this bill. It is mandated benefit. The reality is that small business abhors mandated benefits of any kind, even if they seem to solve basic issues. I am sure that you will receive other testimony that can better address this issue. We fall behind so many other countries in the treatment of our citizens, that the least we can do is bring our vast medical expertise to all of the people who need it, without reservation or discrimination, or at the whim of some local body only concerned with reelection based on budget control to the detriment of a non-aligned constituency.

Prepared Statement of Charles W. Newton

Senator Riegle, thank you for the opportunity to testify on this bill. I am Charles W. Newton, M.D. an obstetrician and gynecologist from Grand Rapids, Michigan I have been in private practice in this location since 1974. A small percentage of my private patients are on Medicaid; and on a volunteer basis, I also supervise a high risk obstetrics clinic, that deals primarily with Medicaid patients. I am also the Vice-Chairman of the Michigan Section of the American College of Obstetricians and Gynecologist, which is comprised of over 970 physicians.

BASIC PROBLEM

There are many problems with the health care system in America, but for me the most compelling concern is the basic dilemma of access to quality care. The problem of access to care has many facets. Two of the most basic are inadequate physician availability in underserved areas, and lack of adequate health insurance for a significant portion of our population.

PHYSICIAN AVAILABILITY

Many communities in Michigan, right now, are without obstetric and gynecologic care. A survey, by the Michigan Section of ACOG in 1989, revealed that the number

of obstetricians who have stopped doing obstetrics, in our state, is 58%. It also showed that the number of OB/GYN residents, who trained in Michigan and leave the state, is 37%. Why do residents leave and obstetricians stop practicing? There are two main reasons. First, the risk of liability exposure is too high for many to accept.

Although the premiums are high, the real threat to a physician is the law suit itself. In a 1990 survey by ACOG, it was shown that 77.6% of obstetricians have had a least one professional liability claim filed against them. Exposure to this kind of risk drives physicians out of practice end reduces patient access to care.

The second force that diminishes access to doctors is low reimbursement rates. In Grand Rapids, Medicaid reimburse at 20% to 50% of prevailing charges for health care services. Two graduating residents from my hospital tried to serve the city of Grayling with obstetric and gynecologic care, but were able to survive on the Medicaid reimbursements and were forced to leave. Most businesses could not survive at these rates.

INSURANCE

Too many of our citizens lack health insurance altogether, and the Medicaid program, that is currently in place, has many problem, often causing delays and unattainable coverage. With Medicaid, the usual eligibility denial for patients was due to failure to comply with procedural requirements. The client information system is also very difficult to access. The physicians find the Medicaid program difficult too. The "red tape" required to get claims satisfied is cumbersome and creates excessive cost and time for physician's offices. Most doctors are unwilling to deal with this hassle.

HEALTH AMERICA BILL

The Health America bill does address the problem of access to care. And I think the focus in the first year on pregnant women and children will be a tremendous benefit to this portion of our population. With respect to physician availability, I feel the Health America bill needs to include more specific measures that would attract physician participation. First, I am concerned about the proposed reimbursement rates for health services. Reimbursement schedules are planned to be similar to the present Medicare rate. I am not sure how Medicare schedules will match up with services for pregnant women, but I hope that they are better than the present Medicaid rates, so that physicians would be attracted to participate.

The bill also proposes the development and staffing of community health centers, for underserved areas. However, it does not sufficiently address the basic problem of liability exposure. I feel the bill should incorporate specific measures, similar to those outlined in Senate bill 489, titled Ensuring Access Through Medical Liability Reform Act, proposed by Senators Hatch and Jeffords.

For example, I feel that we should establish a system of voluntary or mandatory arbitration that would be binding. Also a compensation fund should be established for individuals injured in the course of receiving health care to cover economic losses. A ceiling should be placed on noneconomic damage awards. And we should set a schedule of percentage limitations for attorney contingency fees.

Cost containment is an important issue, as the cost of health care in our country is very high. This bill proposes practice guidelines and managed care as methods of cost containment. Practice parameters are still being evaluated by the American Medical Association, and it is not clear what role they should play. Further analysis may reveal that they will reduce unnecessary care, but I feel there are potential problems with strict guidelines and practicing medicine in a "cookbook" approach. Who will write the guidelines? How many different human illnesses and conditions can be covered by guidelines? How often will guidelines be revised to keep up with the constant changes and improvements in medicine? What are the liability risks for physicians if practice parameters are utilized?

We do have some experience with managed care, and it has been shown to reduce costs. But quality of care can be easily compromised and patient satisfaction can be diminished.

A very positive aspect of the bill is the incorporation of preventive care measures such as mammograms and pap smears which have been shown to lower costs in the long run.

I support the concept of health insurance for every American. But the insurance does need to be "user friendly," for patients and physicians.

The ideas in this bill for standardized claims forms and the insurance consortia will potentially streamline the cumbersome paperwork that is needed now.

I also think the scaled co-pays will make the system more efficient by eliminating some of the unnecessary visits.

I think some attention should also be given to educational and awareness programs for patients. Medicaid patients right now have a very high rate of no-shows at their visits and they are very often late to seek care.

PREPARED STATEMENT OF SHIRLEY PANT

Good Morning. My name is Shirley Pant. Thank you Senator Riegle for the opportunity to be able to tell you about the struggles and fears I have experienced over the past couple years after being diagnosed with breast cancer. I am 60 years old. am uninsured and have been for most of my life.

In May of 1990 I detected a lump in my breast. At the prodding of my daughters I went to see a doctor and was run through a battery of tests. It was soon determined that I had to have surgery. I had this feeling of dread that the doctors would find cancer—and they did.

My doctor knew I was uninsured, but was kind enough to say that the first priority was to get me well. He found me the least costly cancer doctor to do the mastectomy. All the while my mind was filled with thoughts of how I was going to pay for this.

As I mentioned I am uninsured. I do work though, and have all my life. I singlehandedly raised four children and own my home. I work for a bakery. It is a small business with six employees. The owners cannot afford to provide health benefits. I make $4.75 per hour. I work part-time, mostly third shifts. take advantage of extra hours when I can. But Senator, what I earn cannot begin to cover an individual insurance premium. Or the $10,000 in medical expenses I have been trying to pay off. You just can't squeeze blood from a turnip.

After the surgery, I wasn't able to work for three months. Also, I had chemotreatments every two weeks for six months. Every treatment cost me at least $700, but what choice did I have?

What really makes me mad though is the bill collectors. I was hardly back home from my surgery and they were calling me . . . asking me how I intended to pay. I told them I didn't know, but said that they would get their money slowly. They had the nerve to tell me I shouldn't have had the procedure if I didn't know how to come up with the money to pay them. They even suggested I get another job that pays more. Let me tell you that for a woman of 60 there aren't many jobs available. Especially jobs that pay more than what I am making. For one bill I promised to pay $50 per month. They said that was too little and now they've acted to garnish $75 of my wages per month. Some weeks I don't know how I am going to put food on the table. Thank goodness for my family and friends at my church.

I have shopped around for health insurance policies in the past. All were way out of my price range with monthly premiums of $375 or more. That is at least three-quarters of my monthly income. Now, with my history of cancer, I am considered uninsurable. I do have a small catastrophic health policy. If I would have to be hospitalized, my insurance would pay the first $50 of each day in the hospital. I had my breast surgery as an outpatient so this policy didn't cover anything.

I also tried to get public assistance. I don't qualify for disability or SSI. I have to wait five years to get Medicare. My income is low but I was still turned down for Medicaid. I thought that they told me I had to sign over my home in order to get financial help. To this I said, "No Way—I have worked too hard." Since then, I have learned from your staff that my home doesn't count in being eligible for Medicaid. Also, most people get turned the first time. I am now working with your office to see if there is help.

It has been a year now since the cancer. In February I was given a clean bill of health with instructions to have a mammogram in July. I never kept the appointment. I have enough bills to pay without $95 more for this kind of test. My doctor has arranged for me to get my prescriptions at no change. He also said I have to have more tests in October. Since I doubt much will have changed, I won't be able to go then either.

Senator Riegle I would be willing to pay for an affordable price for health insurance if a plan were available. With my health history my daughters are also at risk for breast cancer. I just hope that a solution to the uninsured will be found. I don't want them having to some day face what I have had to.

PREPARED STATEMENT OF SENATOR DONALD W. RIEGLE, JR.

America's health care crisis is part of a larger problem of a shrinking American middle class where our people have less and less economic power to meet their basic needs. Skyrocketing health insurance costs for those who have coverage—and the growing group of Americans with no health insurance coverage—are signs that our health care system must be reformed. We can and must do better—and that is the goal of the comprehensive health care plan1 called HealthAmerica, that I recently introduced with several of my Senate colleagues.

I held a series of Subcommittee hearings in Michigan over the past two years (The hearings were held in Southfield, Warren and Lansing with over 600 total in attendance). Michigan citizens who testified were absolutely integral to this process.

The purpose of today's official U.S. Senate Finance hearing is to continue the process of getting the input of Michigan citizens about HealthAmerica. We will hear from several distinguished panels of individuals or families affected by rising health care costs or currently without any coverage, representatives from labor and business and health care providers. I also want to invite the audience to submit written testimony that will be included in the official record of this hearing.

In Michigan today, close to a million people are without a penny of health insurance, and 300,000 of them are children. Nationally, an estimated 34 million Americans have no health insurance coverage.

Those who do have health insurance are finding their rates rising sharply and their coverage being reduced by rising deductibles, co-payments, and diminished benefits. These problems affect all of us. Hospitals, emergency rooms, and trauma centers are closing, and doctors are finding it harder to treat a growing number of low-income people because of inadequate Medicaid payments or no payments at all for uninsured people. In Michigan alone, hospitals lost over $350 million last year providing care for those who could not or would not pay. When providers who offer essential services are forced to shut down, we all suffer.

HealthAmerica is the product of almost 2 years of work of the Finance Subcommittee on Health for Families and the Uninsured which I chair. In the 101st Congress, this Subcommittee was created at my request to enable us to find a solution to these problems. I have been introducing bills to reform the health care system for 10 years. These are problems this country has had for decades. Until now, the inertia's been too strong to solve the problem. This time, we've got momentum and a solution is within our reach. But HealthAmerica needs your support because its going to take people across the country, working together to solve this problem.

HealthAmerica addresses two major shortcomings of our health care system—rising health care costs and lack of health care coverage for millions. Our plan would provide high quality health care for everyone who currently does not have coverage. We build on the existing private and public health care system, which asks employers to provide health care for their employees and dependents. We create a new public health insurance program, AmeriCare, to cover everyone not directly covered through their employers.

The principles used in designing our program mark a breakthrough that will, in stages over the next five years, bring basic health insurance coverage to every person in America. They do so by implementing important cost-saving reforms at the same time we broaden health insurance coverage, starting with the 10 million American children and all pregnant women who now lack insurance.

We have developed, for the first time, a significant health care cost-reduction program. We do this by reducing unnecessary care, decreasing administrative costs, and restricting health care price increases. HealthAmerica will make health care more affordable for employers already providing coverage and encourage those currently not providing coverage to provide coverage. Health care would also be more affordable to those who have coverage and those currently without coverage.

HealthAmerica will cost about $6 billion in the first year, but that's only one-half of 1% of our federal budget, which is $1.4 trillion. In fact, our cost-reduction program would save over $80 billion during the next five years.

Many businesses would like to provide health care coverage but the costs are too high. Nationally, 70 percent of workers in small businesses (those with less than 25 employees) have health insurance.

Our bill has a series of special provisions to ease the burden on small businesses including tax credits and improved deductions for the self-employed, reform of the private insurance market for small groups that would spread the risk over more people and stabilize rates or bring them down, and special phase-in periods for coverage. Since we phase-in our cost-reduction program sooner than the coverage of the

uninsured, private health care plans will be more affordable for small businesses through these reforms.

Under HealthAmerica, anyone who does not directly receive health insurance through an employer will have access to affordable, high quality health care through our new public health insurance program, AmeriCare. Unlike Medicaid, which it replaces, AmeriCare is not a welfare program. All people will be eligible for its coverage, including workers and their families employed by businesses not providing private health insurance.

AmeriCare will provide a uniform basic health benefit package and higher reimbursement rates for providers—both significant changes from the current Medicaid program. Raising provider reimbursement payments would increase physicians' participation in the program, increasing the availability of health care services.

States would administer AmeriCare within these tighter federal standards, creating a uniform health care program. And we increase federal funds available to the states for AmeriCare during the time the program is being phased-in.

HealthAmerica proposes a number of cost-cutting measures that would bring the price of health insurance down, making universal health care affordable. HealthAmerica would standardize paper work, saving doctors' time now wasted on hundreds of different insurance forms. It would also give states grants to find ways to cut malpractice insurance for doctors and to make legal disputes less costly. A Federal Health Expenditure Board would be established to help hospitals, doctors and businesses, together, negotiate fair prices for health care services. The Board would also establish voluntary spending goals, and specifically focus on ensuring access to care and high quality health care. And, under HealthAmerica, more funds would go to reducing care that is not needed. Doctors would get better information on what procedures to use for their patients. Currently, 30 percent of major medical procedures are thought to be unnecessary. These and other measures in the bill would save over 80 billion dollars in national health care spending over five years.

This bill is a top priority of the Democratic leadership in the Senate and I am determined to see that we enact affordable, high-quality health care for all Americans. The Finance Subcommittee which I chair is holding hearings on the bill both in Michigan and in Washington, D.C. Currently, I have scheduled hearings in Washington for September 23rd and 30th.

I consider HealthAmerica a starting point; I want to continue the dialogue with all interested parties in developing an efficient, sensible, and comprehensive health care reform legislation.

Attachment.

MICHIGAN

Numbers uninsured

• Close to 1 million uninsured in Michigan; 300,000 are children.

Uncompensated care

• Hospitals spent over $350 million for those who had no insurance or did not pay.

AmeriCare

• AmeriCare would replace Medicaid for acute and primary care services. Everyone who does not receive coverage through an employer is eligible.

• More federal funding is provided, starting with a 20% increase over a state's current match. Michigan's match would increase by 11%, reaching 67% (it is currently 56%). For every dollar, 67 cents would be from the federal government and 33 cents from the state.

• Increased reimbursement rates to levels at least equivalent to those based on Medicare rules. Michigan fees are now on average 62% relative to Medicare prevailing charges.

• Standard benefits

Scope and duration limits on services are eliminated. Currently, a state can limit its benefits, for example, limit the number of hospital visits. Current Medicaid population would continue to receive whatever benefits the state offers beyond the core package of acute care benefits.

State consortia

• Increases Michigan's ability to control costs. State could convene negotiations for payment rates and other cost cutting measures between all purchasers and providers.

• Gives states the ability to include AmeriCare and Medicare in developing reimbursement guidelines through waiver authority under the Secretary of Health and Human Services (HHS).

• Provides grants to states through HHS of at least $150,000. Michigan would most likely get more money since it is a bigger state relative to other states across the nation.

Business including the Auto Companies would benefit

Companies that provide health insurance are finding that their rates are going through ceiling because they are having to carry the load of the costs that are accruing for uninsured people and uncompensated care.

This affects our ability to compete internationally. Chrysler's health care cost per vehicle ($700) exceeds our international competitors' costs by from over $300 to almost $500 per vehicle.

Bill would help Michigan businesses by:

• reducing uncompensated care cost shift, 10% to 15% of total health care costs; and

• eliminating responsibility for a spouse's benefits, a 7% to 10% saving of total health care costs. (Spouses would receive care through their primary place of employment.)

• Federal Health Expenditure Board and state consortia would increase bargaining power with providers so more adequate and fairer prices are established.

• There would no longer be a need for a back up plan for unemployed or workers on lay off because AmeriCare would be available to everyone.

• The current cost shift from inadequate public programs would be significantly reduced by eliminating Medicaid and mandating higher reimbursement rates.

• Due to size of companies—auto companies, in particular, would be a key player in Federal Health Expenditure Board.

• Standardized billing and claims processing would reduce overall administrative costs.

• Unnecessary care will be reduced through more outcomes research to determine appropriateness of services, technology assessment and the use of practice guidelines.

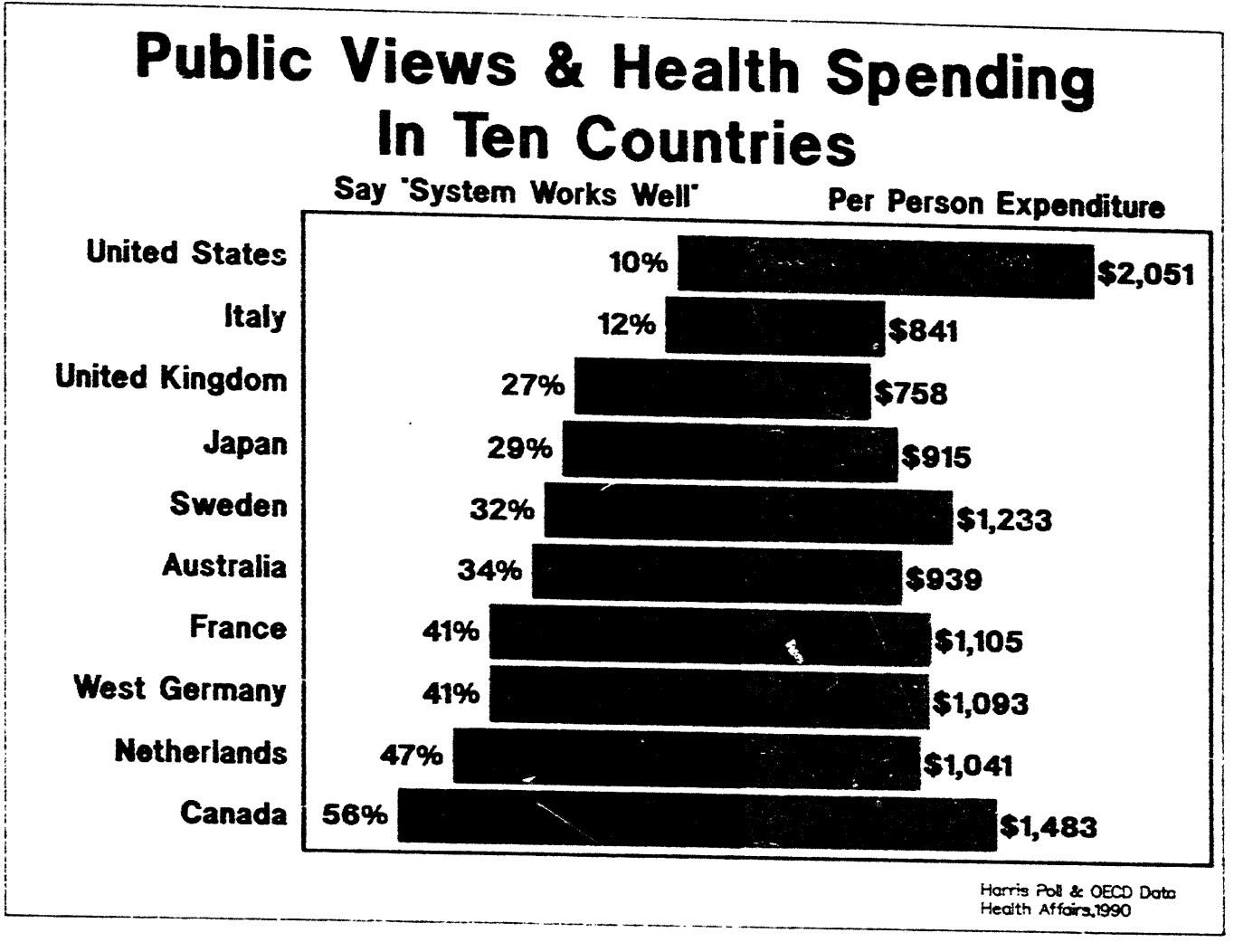
• Costly state mandates would be preempted allowing for single national plans.

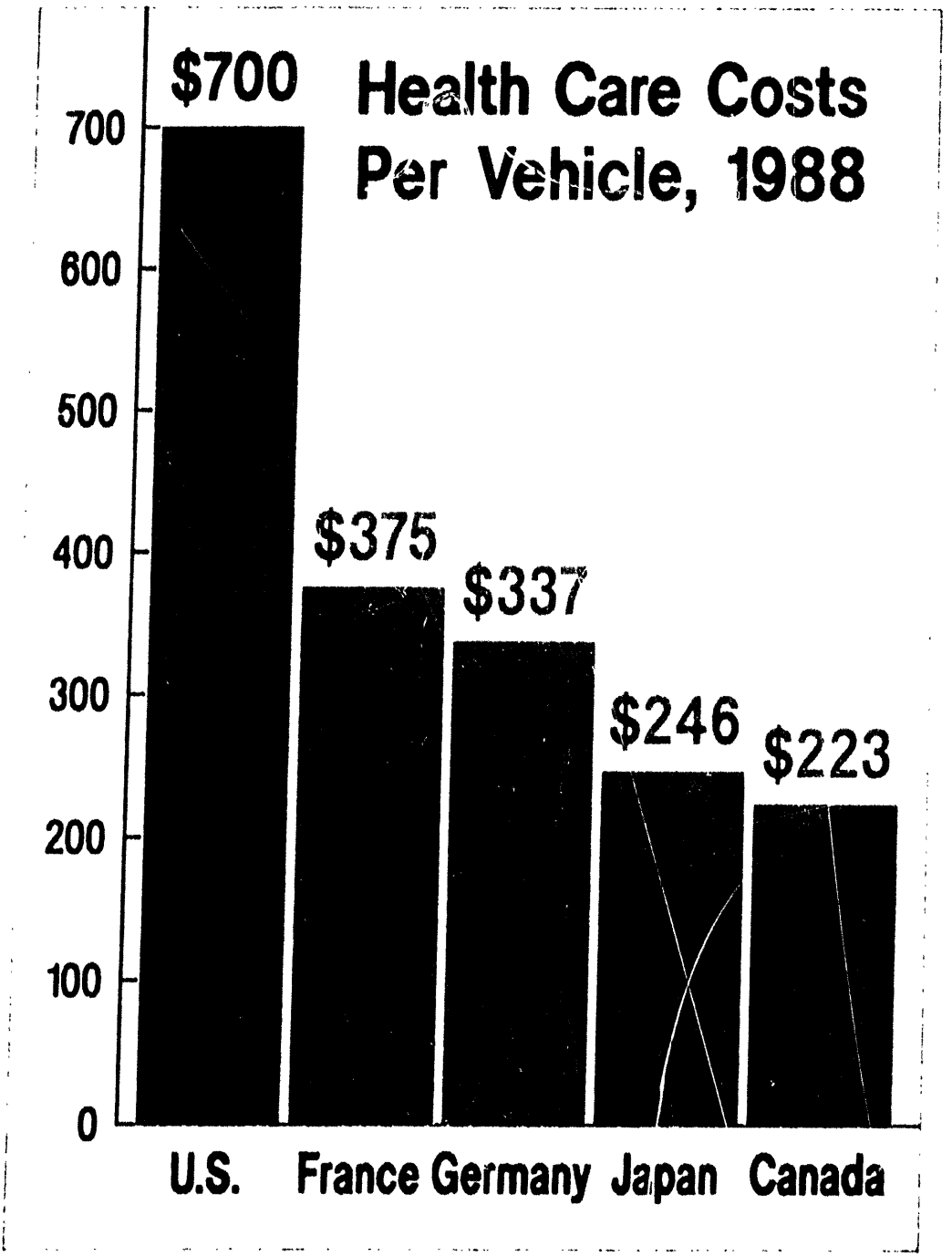
• The use of efficient managed care system would be encouraged by removing current state restrictions on managed care.

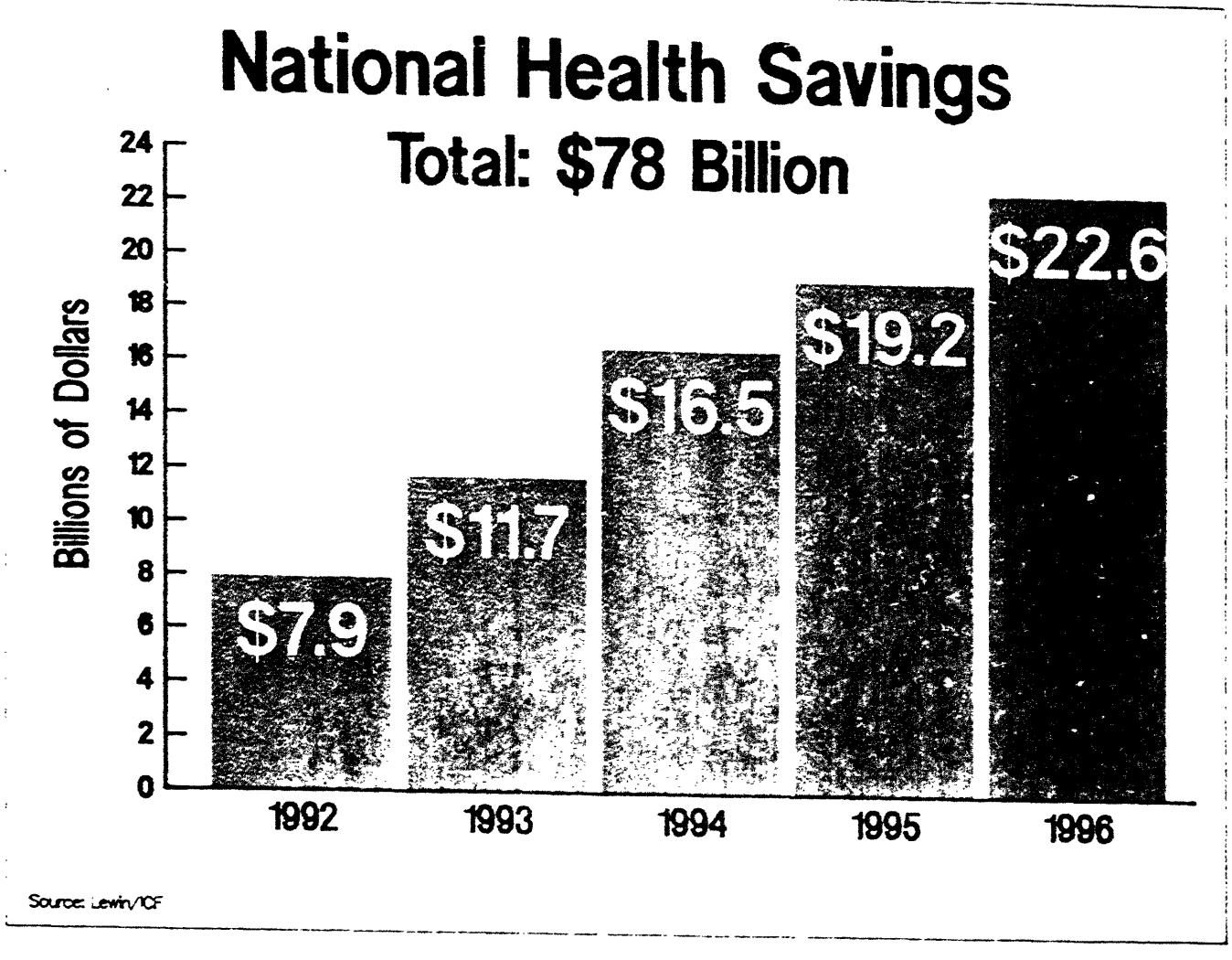
• State quality organizations would improve quality and utilization review.

Health America: Affordable Health Care for All Americans

I. Private Coverage	Employers Required to Provide Coverage or Contribute to the Public Plan
II. Public Coverage	Federal-State Public Program ("AmeriCare") • Replaces Medicaid • Covers all Americans not covered by private insurance or Medicare
III. Comprehensive Cost Reduction Program	• Reduce Unnecessary Care • Cut Administrative Costs • Restrain Price Increases
IV. Small Business Assistance	• Tax Credits • Insurance Reform


Public Views & Health Spending
In Ten Countries
Say "System Works Well"
Per Person Expenditure
United States
10%
$2,051
Italy
12%
$841
United Kingdom
27%
$758
Japan
29%
$915
Sweden
32%
$1,233
Australia
34%
$939
France
41%
$1,105
West Germany
41%
$1,093
Netherlands
47%
$1,041
Canada
56%
$1,483
Harris Poll & OECD Data
Health Affairs,1990


Health Care Costs
Per Vehicle, 1988
$700
$375
$337
$246
$223
700
600
500
400
300
200
100
0
U.S.
France
Germany
Japan
Canada


National Health Savings
Total: $78 Billion
Billions of Dollars
24
22
20
18
16
14
12
10
8
6
4
2
0
$7.9
$11.7
$16.5
$19.2
$22.6
1992
1993
1994
1995
1996
Source: Lewin/ICF

SUMMARY OF HEALTHAMERICA: AFFORDABLE HEALTH CARE FOR ALL AMERICANS

OVERVIEW

The legislation will assure every American basic health insurance coverage, either through a plan provided by an employer or through a Federal-State public insurance program, called AmeriCare, that will replace Medicaid.* Universal health insurance coverage will be coupled with a comprehensive program to control health care costs and with provisions to reflect the special needs and problems of small business.

EMPLOYMENT-BASED COVERAGE

--Business responsibility. Businesses will be offered a choice of providing coverage meeting minimum standards for employees and their families or making a contribution to the public plan. The contribution will be set at a percent of payroll. This contribution will encourage employers to provide health insurance while providing a substantial subsidy to employers, especially small employers, with a high percentage of low-wage or part-time workers. The contribution will be set at a level that will maximize private coverage for the working population without imposing an excessive burden on employers.

If an employer chooses to make a contribution, he or she will be required to facilitate the process of enrollment in the public program by providing his or her employees with enrollment forms and information about how to apply for coverage. States will be given the option to require those employers who elect to make a contribution to

* Except for long-term care services.

the public program to collect the employees' portion of the premium. In the absence of this requirement, employers will be allowed to voluntarily collect premiums on behalf of employees.

--Individual responsibility. Employees will be required to accept coverage for themselves and their families if offered by their employers and pay a share of the premium as well as co-payments and deductibles, if required under the employer plan. A similar obligation will be assumed by workers whose employers make a contribution to the public program. When the plan is fully phased-in, certification of health insurance coverage will be required for each individual claimed as a personal exemption. Certification of coverage will also be required when applying for government benefits such as government loans or food stamps as a condition of receiving benefits.

--Basic benefit package.

Covered services. Plans must cover:

- o hospital services
- o physician services
- o diagnostic tests
- o limited mental health benefits
  - + 45 days of inpatient care
  - + 20 outpatient visits
- o Pre-natal and well-baby care
- o Preventive health benefits
  - + mammograms
  - + pap smears
  - + well child care

Cost-sharing. Maximum employee cost-sharing under basic plans is:

- o 20 percent of the premium
- o deductibles of $250 per individual and $500 per family

- o co-payments of 20 percent (except for outpatient mental health services, for which 50 percent co-payments may be charged)
- o out-of-pocket catastrophic cap on liability for covered services of $3,000
- o wage-related cost-sharing may be used for deductibles and catastrophic cap
- o employee premium share and co-payments and deductibles will be subsidized by the public plan for low-income workers (as described in the public plan section, below)

Actuarial equivalency. To assure employer flexibility to adapt the plan to the needs of the particular work force, employers may offer plans that do not meet minimum standards as long as the employer contribution to the plan offered is actuarially equivalent, pursuant to guidelines issued by the Secretary, to what would be provided under the basic plan. Under an actuarially equivalent plan, basic services must still be covered without limits on scope and duration, except as specified in the basic plan, but the level of cost-sharing could be adjusted. For example, an employer who offered a service that was not required to be covered could require his or her employees to pay a larger share of the premium or charge a higher deductible. An employer with a lower deductible could have a higher catastrophic cap.

--Employees to be covered.

o Full-time workers. If an employer provides private coverage rather than making a contribution to the public plan, all workers and their families working 17 1/2 hours a week or more must be covered. An employer may choose to make a contribution to the public plan for workers employed less than 17 1/2 hours per week even if direct coverage rather than the payment is chosen for other workers. For purposes of computing the wage base for contributions to the public plan, the employer may exclude workers for whom coverage is not mandatory, including employed children covered under a parent's plan

and workers with two employers receiving coverage under another employer's plan.

o Less than full-time workers. The required employer premium contribution for workers employed 17 1/2 hours per week or more and less than 25 hours a week may be reduced based on the ratio of hours worked to 25. The required contribution for employees working less than 17 1/2 hours per week is at least 50 percent. Employees who are charged premiums higher than 20 percent of the cost of a basic plan as the result of this provision may decline employer coverage and receive coverage through the public plan.

o Two family members employed. Each employer is responsible for primary coverage of his or her employee. If a family member is covered under another plan, a worker may decline coverage for that family member. Parents may choose which employer plan will cover their children. A worker receiving primary coverage from an employer may also elect to participate in the plan of another working family member and receive secondary, wrap-around coverage from that plan. In the case of a two-worker family, the primary worker's premium payment, if any, to the primary employer shall be adjusted to reflect savings to that employer as the result of not bearing responsibility for primary coverage of the secondary worker. A similar adjustment shall be made for workers receiving retirement health benefits from a previous employer.

o Employed child. Coverage may be waived for a working dependent child covered under a parent's plan.

--Additional features.

o Waiting period. The waiting period for coverage may not exceed 30 days. If the employer elects to impose a waiting period, the employee may elect to receive coverage from the employer during this period by paying 102 percent of the combined employer and employee share of the premium.

o Pre-existing condition limitations on coverage. When fully phased-in, no limits on coverage may be imposed based on the existence of pre-existing conditions.

o Consumer protection. A set of legal protections will be established for insured individuals, including the right to full information on plan provisions and the right to appeal coverage decisions.

PUBLIC PLAN

Medicaid will be replaced* by a new Federal-State program of public coverage called AmeriCare. The program would be administered by the states subject to national standards for eligiblity, reimbursement, and coverage. All Americans not covered by employment-based coverage will receive coverage under AmeriCare.

Benefits under AmeriCare will be the same as for employment-based coverage, except that Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) will be available under the public program. Individuals below the poverty line will have access to optional Medicaid services that the State chooses to provide. Individuals below the poverty line covered by an employment-based plan will also be entitled to receive such services through the public plan.

Specific provisions include:

--Premiums. Individuals below 100 percent of poverty will pay no premium. Individuals between 100 and 200 percent of poverty will pay premiums on a sliding scale basis. Individuals above 200 percent of poverty will pay premiums equal to the average actuarial value of the coverage, capped by a percent of income reflecting ability to pay.

*Except for long-term care services.

Workers receiving coverage through the public plan will pay 20 percent of the actuarial value of coverage, unless their incomes are below 200 percent of poverty.

--Subsidy of low-income workers receiving private coverage through an employer. The public plan will subsidize the premium share of workers with family income below 200 percent of poverty. Premiums will be completely covered for below-poverty workers for basic plan benefits.

--Consortia. States will be encouraged to establish purchasing consortia to reduce the overall rate of health care cost inflation (see below); AmeriCare and Medicare can participate in these consortia.

--Managed care. States will be encouraged to set up and enroll beneficiaries in cost-effective managed care systems. Safeguards are included to assure that no enrollee will be forced to choose a managed care alternative.

--Provider reimbursement. Providers will be reimbursed at levels at least equivalent to the level that would be provided by the use of Medicare reimbursement rules. Reimbursement will be raised in phases.

--Scope and duration. No limits may be placed on scope and duration of coverage for required services.

--Phase-in. The public plan will be phased-in. All children and pregnant women will be assured coverage in the first phase.

--Financing. The public program would be financed by state and Federal contributions. States would receive an enhanced Federal match, phased out over time, for coverage of newly eligible persons and other new program costs in the public program. This enhanced match would be a specified percent increase over a state's current matching rate for the Medicaid program.

EXPANDING ACCESS THROUGH AN IMPROVED DELIVERY SYSTEM

Insurance coverage alone will not guarantee access to care for many individuals in rural and inner-city areas where there is an inadequate supply of health care providers. Over the next five years, approximately $1.2 billion in additional funding will be invested in the creation of community health centers to provide primary care services in such underserved areas. This additional funding will provide the capacity to serve an estimated 5.4 million people each year.

REDUCING THE BURDEN OF HEALTH CARE COSTS

Universal health insurance coverage itself significantly reduces the cost of health care to businesses and individuals currently purchasing insurance. Uncompensated care raises private health insurance premiums an estimated 10-15 percent.

In addition to the reduction in cost-shifting, the program includes a comprehensive program to lower health care cost inflation and total health care costs. The strategy is organized around steps to reduce unnecessary and ineffective care; to reduce the excessive administrative costs of the current pluralistic payment system, and to limit unrestrained price and volume increases by providers. Specific measures include:

Reducing unnecessary or ineffective care

--Outcomes research/practice guidelines dissemination. The Pepper Commission estimated that unnecessary or ineffective health care added as much as $18 billion annually to health care costs. The legislation will raise the authorization level for the Agency for Health Care Policy and Research by $50 million, to enable it to conduct additional outcomes research and develop practice guidelines for more procedures. The current emphasis on Medicare services will be supplemented by an equal emphasis on the services

that are delivered in the private market. Government programs will be required to use practice guidelines in utilization review activities. Additional measures will be taken to assure dissemination of guidelines, once developed, to providers and payers (see below).

--Technology Assessment. The current public initiative through the Agency for Health Care Policy and Research to analyze the appropriate use of technology will be expanded. Cooperation between the public and private sector and coordination of private sector efforts will be encouraged. Federal matching grants will be available through the Agency for Health Care Policy and Research for private sector technology assessment initiatives.

--Encouragement of managed care. Managed care works by encouraging use of the most efficient providers and minimizing unnecessary or ineffective care. Managed care will be encouraged by the following measures:

- State legislative barriers to managed care will be pre-empted.
- Small businesses (which employ 30 percent of all American workers) will be given guaranteed access to managed care through small business insurance reform (see below).
- Through small business insurance reform (see below), insurers will be given additional incentives to develop cost-effective systems of managed care.
- The public program will make managed care options available to those not covered by employment-based plans.
- The data base necessary for effective managed care will be enhanced by the standardized data and evaluation of providers described below and by evaluation research and development of practice guidelines.

Eliminating Unnecessary Administrative Costs

Four programs will be established to reduce the excessive administrative costs of our pluralistic payment system.

--Standardized claims forms. The Federal Health Expenditure Board (see below) will be required to develop and implement standardized claims and data forms. This will reduce administrative costs for providers, who must now deal with a multiplicity of forms provided by different payers.

--Insurance Consortia. (See Encourage State Consortia, below). By requiring small insurance companies to combine for the purpose of paying providers, the legislation will dramatically reduce the number of payment entities with which providers must deal. This will make possible significant economies of scale in claims processing, facilitate electronic claims processing, and reduce administrative costs of providers.

--Quality improvement agencies. New agencies will be established in each state to work with providers on a program of continuous quality improvement and implementation of cost-effective methods of delivering care, including practice guidelines. Providers periodically certified by the agency as practicing efficient, quality care will be exempt from utilization review by insurers during the period of the certification, not to exceed one year. This step will focus utilization review where it is most likely to be cost-effective and enhance risk-management activities.

--Small business insurance reform (see below). By reducing the costs of the continuous enrollment and disenrollment endemic to the current system of insuring small businesses, by promoting more effective price competition, and eliminating or reducing the high costs associated with medical underwriting, this reform will reduce the average administrative costs associated with selling insurance to businesses of 25 employees or fewer from 25 percent of premium to 15 percent. For companies with ten or fewer

workers, where administrative and sales costs are often as high as 40 percent, savings will be even greater.

Assure provider price and volume restraint.

--**Federal Health Expenditure Board.** An independent agency with the stature and independence of the Federal Reserve Board will be established to set national expenditure goals, in total and by sectors of the health care industry. Advisory goals will also be established for states and regions. The Board will convene providers and purchasers to conduct negotiations on rates and other methods of achieving the expenditure goals. Negotiators may recommend adjustments of the goals to the Board. The Board will publish recommended rates and other measures to achieve the goals for the use of purchasers and providers. Recommended rates and other measures will be binding if the negotiations are successful unless State Consortia (see below) establish different payment methods, rates, or other meaures that could be successful in achieving the goals.

--**Encourage State Consortia/Innovative cost control programs**

States will be required to establish insurance/purchasing consortia, which would, at a minimum, require insurance companies with small market shares to participate for the purpose of reducing administrative costs. These consortia would also be encouraged to take other cost-containment actions. To encourage states to use consortia, states will be given the flexibility to have both Medicare and AmeriCare participate. States will also be given grants to establish and evaluate these consortia.

Mandatory functions. The consortia will make all direct payments to providers on behalf of insurance companies with small market shares (most of the estimated 1200 insurance companies marketing health insurance) and will work with providers to establish paperless processing and "smart card" systems for reimbursement that will reduce administrative costs and burdens and

take advantage of economies of scale. Larger insurers and the public programs will be allowed, and, at state option, required to join these insurance consortia.

Optional functions. Optional functions of the consortia may include:

- o price negotiation;
- o volume negotiation;
- o capital allocation;
- o rational distribution of providers;
- o data collection;
- o consumer protection;
- o promotion of managed care/competition.

If state consortia establish effective methods of achieving overall state goals established by the Federal Expenditure Board, state rates or other methods may be used in lieu of Board published rates.

--Develop and disseminate cost and quality data on individual providers.

The Federal Health Expenditure Board will collect, analyze, and disseminate data that will assist purchasers of care and consumers in evaluating the efficiency and quality of individual providers. This will assist in the development of managed care networks, in identifying quality providers for patients, and in encouraging providers to improve their performance.

Additional Cost Control Actions

--Pre-empt state mandates. The current ERISA pre-emption of state regulation of the content of employer health plans for self-insured plans will be extended to all employment-based health plans. Federal standards will replace state standards.

--Malpractice. A grant program will be established to provide states incentives to experiment with alternatives to the tort system for reimbursing and protecting the victims of malpractice and with the use of practice guidelines in malpractice cases. The Institute of Medicine or similar independent organization will conduct an evaluation of the current status of knowledge about the malpractice problem in all its facets and make recommendations to the Congress.

--Health care cost control research and demonstration program. A new program of health care cost control research grants and demonstrations will be established in the new Agency for Health Care Policy and Research. Grants will be made to develop effective methods of health care cost reduction. A similar program in the '70s led to the development of the DRG program.

SPECIAL PROGRAMS FOR SMALL BUSINESS

The legislation recognizes the special problems faced by small business in providing health insurance to their workers and addresses these problems in a number of ways.

--Contribution to public coverage. By offering businesses the opportunity to make a contribution based on a percentage of payroll instead of providing coverage directly, the legislation reduces the cost substantially to businesses, often small businesses, that employ predominantly low-wage or part-time workers. This alternative is far less costly to such businesses than providing coverage but will assist them in attracting a qualified work force.

--Phase-in of Small Business Responsibility. Small businesses with fewer than 100 workers will be allowed a phase-in period before they are required to provide or contribute to coverage for their workers. For businesses with 25 to 99 workers, the phase-in will be four years. For businesses with fewer than 25 workers, the phase-in will be five years. These transition periods will allow small business insurance reform time to take effect and give small businesses time to plan for the additional costs they will be expected

to incur. Businesses with 25-99 workers will have 4 years to voluntarily provide coverage to workers. If at the end of 4 years 75 percent of the currently uncovered employees of these businesses have been covered, then employers in this group will not be required to provide coverage or pay a contribution to the public program. The same rule will apply for businesses with fewer than 25 employees, except that they will have 5 years to voluntarily provide coverage.

--Small business insurance reform. Federal standards for health insurance sold in the small group market will: remove barriers to access to group health insurance by eliminating pre-existing condition exclusions and denials of coverage on the basis of health status; promote equity in insurance premiums, by moving rate-setting toward a community-rated system; and improve the affordability of coverage for small employers, by preempting state benefit laws and ensuring access to managed care. States will be required to provide information and technical assistance to small employers and consumers seeking to choose a plan.

--Special treatment of new small businesses. Recognizing the fragility of small businesses in their early years, the legislation allows new, small businesses a reduced obligation with regard to providing or contributing toward health insurance coverage. Small businesses with fewer than 25 workers will have no obligation to provide or contribute to coverage during their first two years. In the third year, the contribution they will be required to make to the public plan will be one-half the normal level.
In the fourth year, such businesses will be required to fulfill the same obligations as other businesses.

--Special treatment of small businesses that have not previously provided coverage. During the first five years after enactment, small businesses that have not provided coverage to their employees during the year prior to enactment of the legislation will be allowed to buy insurance paying providers under Mediare rules.

This program will allow these small businesses to provide coverage at lower costs and will encourage them to begin to provide coverage voluntarily during the transition period. The Secretary shall study this program and report to the Congress on its effectiveness.

--Improved tax treatment for the self-employed. Currently, the owner-operator of an unincorporated small business is only allowed to deduct 25 percent of the cost of his or her own health insurance premiums from income for tax purposes, and even this deduction is due to expire in December, 1991. By contrast, the cost of health insurance for the owner-operator of an incorporated business is fully deductible. This provision would allow the self-employed owner-operator to deduct 100 percent of the cost of his or her own health insurance premiums up to the value of the premium they paid on behalf of their employees. Owner-operators with no employees would be allowed to deduct 100 percent of the cost of the lowest cost small employer plan meeting the basic benefit requirements available in their area.

--Tax credits for small business. In addition to the improved deductibility of health insurance expenses for the self-employed, small businesses that are not profitable enough to be able to afford to provide health insurance coverage to their workers without difficulty will receive a tax credit to cover up to 25 percent of the cost. This credit will be provided to small businesses with fewer than 60 employees for each full-time employee with a salary of less than $20,000, except for high-profit firms in which the employer earns more than $53,400 per year. This credit would be in addition to the deduction currently available for the cost of such insurance.

PREPARED STATEMENT OF ERIC VANDUYNE

Good morning Senator Riegle and other distinguished guests. My name is Eric VanDuyne and I am a doctor in private practice from Swartz Creak, Michigan. I have been in private practice as a primary care physician for approximately 30 years. From the sixties to the nineties the changes in the practice of medicine have bean both rapid and significant—I speak not only of the delivery of care to the patient but also the methods of managing and financing that care.

As Mr. Champney indicated, I participated in many of the activities in Genesee County in the sixties and seventies that lead to the formal organization of a managed care company. Even back to those years there was a level of dissatisfaction brewing among both the providers and purchasers of care. Purchasers of care, such as General Motors and the UAW, developed embryonic programs, such an second opinions requirements, in order to get some type of handle on rampant misuse. From there we evolved a Professional Standard Review Organization (PSRO) in order to systematically and fairly review the activities of physicians and other health care professionals. Subsequently, the professional review movement lead to the development of the state-licensed and federally-qualified health maintenance organization now called HealthPlus of Michigan.

I have been involved with HealthPlus of Michigan from its initial conceptualization and have served as one of its Medical Directors from that time.

It is a pleasure to address you this morning with regard to the HealthAmerica Program. The sponsors of the HealthAmerica Program are to be complimented for seeking to retain (if not favor) managed health care and competitiveness as an integral component. Too often I have witnessed administrators or regulators over-react to an aberrant physician by proposing the creation of a system that would significantly impede the ability of conscientious physicians who properly care for their patients. Managed care certainly provides control over the delivery of health care. However, in my experience, and certainly in cases where managed care administrators are perceptive and intelligent, managed care has the best hope for eliminating inefficiencies and yet not unnecessarily interfering with the judgment that all physicians must use on a routine basis in providing care.

Medicine has not progressed to the point that it can be practiced in a routine or mechanical fashion. Many examples con be used. One that I have used in discussing this phenomena before is a simple headache. The patient comes into my office complaining of a headache. It in only by knowing the patient, his or her family, his or her profession, reading results of various tests and other diagnostic and exam workup, that I have any hope of correctly treating the condition. Medical advise could run anywhere from a no cost alternative (such as getting more rest/taking more time off from work) to exceedingly costly diagnostic tests and further treatment (such as CAT scan, MRI study, consultation treatment by a neuro-surgeon). The point of this example is to demonstrate that the evolution of the practice of medicine has not reached the point that either computers or administrators with Bachelors Degrees in Business can take the place of the physician practicing his trade. The answer also cannot be found in establishing a protocol or standard for each physician/patient episode. Standards can be very useful in identifying extreme abnormalities, but become less useful as you move toward the mainstream of practicing physicians. Indeed, to establish a rigid standard may actually increase utilization and cost without any significant benefit to the health of the population. My participation in managed care over the past many years is testimony to my belief that managed care has the best chance of carefully balancing the issues of access, cost, and quality.

I would like to conclude my remarks by mentioning two additional areas that perhaps could serve as agenda items for the reviewing entities that could be established under the HealthAmerica Program.

First, as briefly mentioned by Mr. Champney, implementation off a fair and efficient means of resolving malpractice claim could have a very significant impact upon the problems of access, cost and quality. The resolution of malpractice claims is costly, lengthy, and every bit of much in need off total reform as the delivery of health care. What makes this terribly relevant to our discussion this morning is the impact that the malpractice problem has to each and every practicing physician. As it exists in the State of Michigan, medical malpractice is a system that rewards the few at the cost of the many. There are both direct and indirect costs associated with the malpractice problem. The direct cost become part of the cost of health care by physician malpractice insurance premium being covered as part of the physicians overall administrative overhead. Perhaps more pervasive than direct costs are the indirect costs, sometimes referred to as the cost of defensive medicine. This refers to

the way in which physicians behavior and practice patterns are affected by their fear of malpractice claims. I wish I was in the position to identify the magnitude off this indirect cost. What I can say is that I see it on a day-to-day basis in my practice.

Therefore, I would respectively suggest that to tackle the many complicated issues involved in the delivery of health care without a meaningful reform of the malpractice problem is to try to treat the disease without identifying one of its major causes. I recognize that the HealthAmerica Program acknowledges the need to study and review the malpractice issue. It is also my understanding that this review will basically take place on a state-by-state basis. The malpractice problem and its affect upon access cost and quality are as severe in the State of Michigan as any other state and perhaps more so. We have experienced cycles of reform in Michigan but the root of the problem has yet to be significantly addressed. I would then ask you, Senator Riegle, as a representative of the State of Michigan to consider more direct federal initiatives in the medical malpractice area.

Secondly, in reviewing the whole continuum of health care delivered in this country, one cannot ignore the terribly disproportionate cost of care to the terminally ill. The heroics of expensive, high technology measures should not interfere with basic ethical considerations involving human dignity. Health core professionals must develop a greater sense of discipline regarding the appropriate use of technology in the context of the terminally ill.

Once again, I understand that the HealthAmerica Program calls for increased funding, for technology assessment. I would suggest that either through the targeting of dollars or the established agenda for this research that a very considered effort be put into critically assessing the disproportioned amount of resource exhausted in the delivery of health care has little or no connection to improving the actual health of the terminally ill.

That concludes my remarks this morning, and once again, I hold high promise for the HealthAmerica Program and its potential for improving the quality of life of all Americans through significantly reform of our health care delivery system.

Thank you very much.

RESPONSES TO A REQUEST BY SENATOR RIEGLE FOR COMMENTS

June 4, 1991

The Honorable George J. Mitchell
Senate Majority Leader
U.S. Senate
176 Russell Senate Office Building
Washington, DC 20510

Dear Senator Mitchell:

We are organizations concerned with maternal and child health working in coalition to assure greater access to health care. America's women and children can wait no longer for the nation to address the health care crisis to be addressed. Although the U.S. health care system is the most expensive in the world, it leaves between 34 and 37 million Americans uninsured, 11 million of whom are children, and 30 million Americans underserved.

We applaud your leadership in working for access to health care for all Americans. We hope that the President, who has stressed the importance of maternal and child health since the 1988 campaign, will join you in showing similar commitment. We look forward to working with you further to develop a meaningful solution to the health access problems faced by millions of Americans.

American Academy of Pediatrics
American Association of University Affiliated Programs for Persons with Developmental Disabilities
American College of Obstetricians and Gynecologists
American Nurses Association
American Public Health Association
Association of Maternal and Child Health Programs
Association of State and Territorial Health Officials
Children's Defense Fund
March of Dimes Birth Defects Foundation
National Association of Children's Hospitals and Related Institutions
National Association of Community Health Centers
National Council of Community Hospitals

AARP NEWS

FOR IMMEDIATE RELEASE
June 5, 1991

CONTACT: Patricia Smith
(202) 728-4788 or LeeAnn
Steinberg (202) 728-4752

AARP COMMENTS ON NEW SENATE LEGISLATION "HEALTH AMERICA: AFFORDABLE HEALTH CARE FOR ALL AMERICANS"

WASHINGTON, D.C. -- The American Association of Retired Persons (AARP) today commended Senate Majority Leader George Mitchell (D-Maine) and several colleagues for introducing "Health America: Affordable Health Care for All Americans."

AARP Executive Director Horace Deets said the bill, which builds upon the work of the Pepper Commission, proposes "a responsible, workable framework that could ensure the delivery of basic health care benefits to Americans of all ages."

The original bill is sponsored by Sen. Mitchell and Sens. Edward M. Kennedy (D-Mass.), Donald Riegle (D-Mich.), and Jay Rockefeller (D-W.Va.)

Deets said, "This bill indicates that Congressional leaders now see the need to combine universal health insurance coverage with cost containment. We are also pleased to see that the sponsors have recognized Medicaid's inadequacies and that they plan to replace it with a broader insurance approach."

"It's now time for the President to join in the effort to reform our nation's health and long term care systems."

More than $2,300 is spent each year for health care costs of every man, woman and child in the United States. Federal and state governments, businesses and individuals can no longer shoulder the cost of the fragmented, inefficient system we now have.

More than 34 million Americans lack access to basic health insurance; millions more have inadequate coverage or risk losing what they have.

The legislation proposed today would be a major step forward toward the goal of ensuring affordable, quality health care for all Americans. AARP looks forward to the opportunity to work with the bill's sponsors to develop financing and long term care provisions, effective cost-containment mechanisms, and a rational transition to any new system. Specific financing and cost containment proposals as well as a long term care package that addresses the needs of Americans--young and old--will be essential to the enactment of comprehensive legislation.

"Ultimately, he public must judge whether the new taxes required by a health care reform proposal are worth the benefits that are gained. But the costs to every American in terms of rising health insurance premiums and out-of-pocket costs, the risk of losing insurance coverage, and the breakdown in available health services are escalating daily," Deets said. "The American people need this problem addressed without further delay."

AARP is the nation's leading organization for people age 50 and older. It serves their needs and interests through legislative advocacy, research, informative programs and community services provided by a network of local chapters and experienced volunteers throughout the country. AARP also offers members a wide range of special membership benefits, including Modern Maturity and the monthly Bulletin.

# # # #

American Hospital Association

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STATEMENT: SENATE DEMOCRATIC LEADERSHIP HEALTH REFORM PROPOSAL

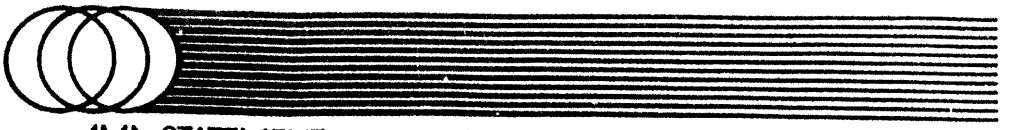
June 4, 1991

ATTRIBUTABLE TO: JACK W. OWEN, INTERIM PRESIDENT

The American Hospital Association applauds the Democratic leadership of the U. S. Senate--and particularly Majority Leader George Mitchell--for placing the issue of health care reform at the top of its legislative agenda for 1991. This proposal promises access to health care for uninsured workers and the unemployed. Further, it would help address the burden of unsponsored care that hospitals currently bear. In building on the existing system of employer-based insurance with a play-or-pay mandate, and in the establishment of a broad public plan for those outside the workplace, the proposal is similar in philosophy to the AHA's recently developed National Health Care Strategy.

We further applaud the use of outcomes research and practice guidelines, technology assessment, and management of care to provide incentives for efficiency for the American health care system. But we have serious concerns about the broad regulatory authority given to both state and federal governments through such mechanisms as state consortia and the proposed National Health Care Expenditure Commission. We have further concerns about the extension of Medicare payment rates--rates acknowledged to be inadequate to cover the costs of treating Medicare patients--to some private purchasers of health care services. In our common pursuit of increased efficiency in health care, we need to assure flexibility to maintain our pluralistic system.

This legislation represents an important step forward in the process of health care reform, and the AHA is committed to working closely with the Democratic leadership to further refine the proposal.



AMA STATEMENT

FOR IMMEDIATE RELEASE June 5, 1991

AMA OPINION: Senate Democratic Leadership Health Proposal

Statement attributable to James S. Todd, M.D.
Executive Vice President
American Medical Association

"The American Medical Association welcomes the introduction of the Senate Democratic proposal to address the problems of our current health care system. With today's action, the Senate Democratic leadership joins the AMA and many others who believe that it is time to reform U.S. health care.

"The Democratic proposal is an interesting, thoughtful first step toward exploring an issue of paramount importance to all Americans. The AMA, as a leader in the health care reform movement, sees great promise in various groups showing increased sensitivity to this vital issue.

"American medicine is the envy of the world. But the system is not affordable for many, and access is not assured for all Americans. Any reform effort must correct these deficiencies.

"The Democratic proposal tracks in some areas -- in concept -- the AMA's own health care reform proposal. There are substantial differences, however. We cannot, for example, gloss over the areas of cost containment and professional liability.

"On the question of an essential benefits package, the AMA believes this feature is vital to making required employer coverage affordable. The AMA essential benefits package provides a good base of necessary services for those who do not now have coverage, while balancing cost considerations.

"The AMA has not endorsed any proposed legislation -- including the Democratic proposal -- currently before the Congress. We continue to advocate equitable, achievable health care reform. We want to work with all parties on forging a consensus health care reform plan that can pass the Congress and be signed by the President.

"We look forward to a productive dialogue with the leadership of the Congress on areas of disagreement and agreement.

For further information, contact: James Stacey 202/789-7419
Brenda Laukaitis 202/789-7447

American Protestant Health Association

A·P·H·A

1701 E. Woodfield Rd., Suite 311, Schaumburg, IL 60173

STATEMENT OF AMERICAN PROTESTANT HEALTH ASSOCIATION
CONCERNING SENATE DEMOCRATIC LEADERSHIP
HEALTH CARE REFORM BILL

June 5, 1991

Contact: Frederick H. Graefe
Baker & Hostetler
(202) 861-1725

The American Protestant Health Association (APHA) applauds the leadership of the distinguished Senate Majority Leader, Senator George Mitchell (D-ME), for making a strong contribution to, along with his Senate colleagues, Senators Kennedy, Riegle and Rockefeller, the much-needed and long-overdue national debate on health care reform.

APHA is a national association of church-related, not-for-profit hospitals, health systems and homes for the elderly, comprising nearly 500 institutions. APHA hospitals include a significant number of major teaching hospitals and disproportionate-share hospitals. At the same time, there is a very substantial number of small urban or suburban facilities, as well as some rural hospitals.

Health care reform is a many-faceted problem. Equal access to the health care system for everyone at affordable rates should be the top priority. The fundamental changes in the system must also include cost containment, small group market insurance reform, malpractice reform, increased health technology assessment and greater emphasis on outcomes research and practice guidelines. All of these issues are addressed in Senator Mitchell's leadership bill.

But that is not the end of the story. The administrative burden on health care providers and patients, has become staggering. As recently reported in the New England Journal of Medicine, over four percent of American physicians' professional time is spent filling out health insurance forms. Any systemic overhaul of the system must address straightforwardly the administrative burden, as the GAO reported yesterday, to providers and patients of the present health care system. Again, Senator Mitchell and his colleagues address this issue in a fair manner.

APHA continues to believe that one of the most promising remedies is managed care. Once again, Senator Mitchell's bill provides incentives to enhance managed care. We strongly believe that such managed care programs would make patients more conscious of costs by limiting tax subsidies to the basic coverage benefit.

Individuals desiring coverage beyond the basic benefit would have to pay for that coverage out of their own pocket. Thus, individuals could buy additional coverage beyond the basic managed care plan from any doctor they choose, but, again, at their own expense.

From a provider standpoint, the controversial aspects of Senator Mitchell's bill deal with the mechanisms for the State purchasing consortia and the National Health Care Expenditure Commission. While many of the functions of these consortia and the Commission would be voluntary, Senator Mitchell's bill does require negotiations at a national level sponsored by the Commission between providers and purchasers to establish all-payer rates within targets. We think it only fair that, if this Commission, or any State consortia, would limit price increases to hospitals to, say, two percent, then the same Commission or consortia should likewise limit wage and supply costs to the same two percent increase.

APHA remains committed, as church-related institutions, to affordable, quality care for everyone. In order to do that, however, our institutions must have revenues in excess of expenditures. Since everyone agrees that one of the articulated goals of health care reform is cost containment, then, in all fairness, that rubric must mean all of the hospitals' costs, including wages and supplies, and not just caps on expenditures for sophisticated health care technology like magnetic resonance imaging machines. The U.S. Supreme Court has recently ruled that unions can set up as many as eight separate bargaining units in a hospital. Accordingly, hospitals must have some assurance that wage issues will be on the table in health care reform just as all other legitimate cost items should be.

APHA wishes to reiterate its appreciation of Senator Mitchell and his distinguished colleagues in advancing the critical issue of health care reform on the national agenda. While we may disagree with some of the particulars, we nonetheless share the same common goal and mission: to provide affordable, quality health care to everyone.

The design of any comprehensive health insurance overhaul necessarily represents hard choices that need to be resolved. Every plan will have its own advantages and disadvantages. Some plans will represent a more radical reform; others will build on existing programs. In order to ease the administrative burdens and financing that any major change would necessarily entail, any comprehensive overhaul will have to be phased in gradually. As a Nation, we must make decisions soon on a long-range direction for our health care policy. Just as the President has identified one aspect -- medical malpractice -- as needing reform, the Senate Democratic leadership has painted with a broader brush and recognizes that we cannot continue to leave millions of Americans outside of our health insurance system. So, we applaud Senator Mitchell and his colleagues and look forward to working with them and the rest of the Congress, as well as the Administration, in the months and years ahead in fashioning a fair and comprehensive health care policy that will guarantee affordable and quality care to everyone.

June 5, 1991

Statement by Ron Pollack on the Mitchell Health Care Reform Bill

The bill introduced today by Senators Mitchell, Rockefeller, Riegle and Kennedy is a major step forward in reforming this nation's health care system. The American people are struggling under the burden of a health care system that is failing. Reform can no longer be delayed.

We congratulate the sponsors of this bill for responding to the dual problems of lack of access to care and escalating health care costs. Nearly 34 million Americans, employed individuals and children among them, have no health care coverage at all. At the same time, health care costs are rising at two to three times the rate of general inflation. Clearly, fundamental reform is needed when we are spending more and more of our nation's wealth and getting less and less security from the high costs of health care. And the American standard of living is deteriorating as a result.

Senator Mitchell and his colleagues have pointed the way to a realistic, politically feasible way of making our health care system serve all American families. Rather than looking the other way, as the Administration has, the Majority Leader and his colleagues have provided us with a thoughtful framework for resolving the growing health care crisis.

Families USA views this bill as an important contribution to the policy debate that lies ahead. We look forward to working with the sponsors on strengthening the cost containment provisions and improving the public program. Specifically, the public program should be federalized and the cost containment provisions should be made mandatory and should apply to all payors. We will also continue to push for long term care coverage for those in need.

This bill provides us with a good framework to achieve a consensus on these issues. We commend Senator Mitchell and his colleagues for their leadership and their commitment to solving one of the most pressing needs facing America today. And we challenge President Bush to face the importance of this issue and join with the Senate Democrats in developing a solution that will provide all Americans with real security and peace of mind.

1334 G STREET, NW • WASHINGTON, DC 20005 • 202-737-6340 • FAX 202-347-2417

Formerly The Villers Advocacy Associates

June 5, 1991

NATIONAL SMALL BUSINESS UNITED

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WASHINGTON, D.C. 20005
202-293-8830
FAX: 202-872-8543

The Honorable George Mitchell
Majority Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Leader:

National Small Business United is pleased that, under your leadership, the Senate Democratic Leadership has produced a thoughtful and comprehensive proposal for reform of our health care system. While there are areas of substantial disagreement between NSBU and the framers of this plan, there are also large areas of common ground--based upon our understanding of the plan outline.

This bill represents a significant step forward from previously introduced proposals. It demonstrates that a real effort has been made to listen to all the disparate groups involved with health care reform. Nevertheless, NSBU remains fundamentally opposed to an employer-based mandate--included in this package as a "play or pay" option, which of course is no real option at all.

The leadership package appears to focus greater attention on the need to contain costs rather than simply providing universal access for the uninsured. Clearly, you and the other framers of this proposal are seriously attempting to deliver on your frequently stated position that we cannot solve the problem of access to health care until we substantially reduce the staggering rate of cost increases generated by our current system. Collecting health care data; establishing an all-payers system; creating common claim, invoice, and billing forms; organizing statewide consortia; and reducing unnecessary care are all very important components of any substantial cost cutting measures. However, these cost control measures need to establish more than simple spending targets. Actual restraint measures must be put in place to hold down costs in the aggregate.

NSBU believes that containing costs will increase the number of insured individuals and improve the chances that health care will continue to be provided to the huge majority of workers over the long term.

Furthermore, we are pleased with the suggestions to reform the small group insurance market and to increase the tax deduction for unincorporated entities. NSBU also proposes that changes be made in the individual insurance market and in the tax treatment of health insurance premiums purchased by individuals.

We will work with you and the other framers of this bill in any way we can to fashion a more acceptable proposal.

Sincerely yours,

John Paul Galles

John Paul Galles
Executive Vice President

United States Senate

WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Lourdes Ancelmo (Reg. nurse)

Address: 1817 N. Magnolia Lansing 48912

Representing: _____

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I invite you to attach a prepared statement or to submit your written testimony:

My concern is we are not really hitting at the root of the problem. "Unaffordable" always comes up as the biggest factor & yet the ~~solution~~ here ~~does not~~ offered in any bill or program I have known or heard about. There are 6,000 non-profit, non for paying hospitals, Blue Cross is non-profit, HMO's are non profit but they all operate like big corporations

Why don't you just tax them + use the money to pay health insurance for the uninsured

Why are health care systems in other countries cheaper + more affordable? Why can other countries provide health care for all their citizens?

If we can just take out the politics from this problem, + not let big industries like hospitals, HMO's doctors etc be more honest + compassionate + share some of their profits with the poor + needy the problem could be on its way to elimination.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate

WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Karen A. Atkinson

Address: 5696 Lebaron Court
East Lansing, MI 48823

Representing: The Natural Health Sciences
517/339-2364

****

I invite you to attach a prepared statement or to submit your written testimony:

and that insurance health care providers be reimbursed by insurance Co
and that more attention be given to supporting and educating people to "the natural health sciences" to help to build people mental or physical health (from a variety of degenerative states) naturally - a very cost effective process to health. The current approach of the medical field to someone with dis-ease (not health) is to cut out or drug up the symptoms. They do not deal with the causes, they do not have the knowledge. A current Mich. Rep. who is one of our clients, very adamantly indicated that 1/3 of the state budget could be eliminated (not to mention a leading population) if our principles and techniques would be adopted (as well as Holistic) but it may be too threatening to the current system at this time.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate

WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: [illegible] RN BSN

Address: B240 Life Sciences
MSU E Lansing 48823

Representing: [illegible] Program. MSU.

****

I invite you to attach a prepared statement or to submit your written testimony:

Having seen the patient & health care worker perspective of the inadequacies of our FFS system for >11 yrs now, I am [illegible] in favor of supporting the [illegible] for a more "equal-opportunity" health care which this bill covers.

— Thank you Senator Riegle!

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Dora Boise

Address: 6089 Park Lake
Bath, Mi 48808

Representing: Head Start & self

****

I invite you to attach a prepared statement or to submit your written testimony:

Previous written testimony turned in (Dora Ostrander) I have 8 son, 8 years old with severe asthma. I now have medical insurance but when he was 6mos-3years old I did not have insurance. He was hospitalized 1-2 times a month. Medicaid would not cover him because our income (unemployment) was too high. Crippled Childrens said he wasn't sick enough. My husband at that time, found a job with insurance but they claimed previous condition and would not insure him. I will be paying ~~them~~ payments on medical bills until after my son becomes an adult.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: C. Gail Edwards-Bryant

Address: 14650 West Eight Mile
Oak Park, Mich 48237

Representing: Automated Benefit Services, Inc (TPA)

****

I invite you to attach a prepared statement or to submit your written testimony:

See attached.

additionally, it's said that no one from a benefits consulting area (other than the insight from an employer) was on your panels.

I embrace the concept on this bill but am very concerned about the delievery.
Good luck with it's passage!

Automated Benefit Services
Specialists in Employee Benefit Plans

14650 West Eight Mile Road
Oak Park, Michigan 48237
Phone (313) 968-3670

September 5, 1991

Sponsors of S1227
c/o Senator Donald Reigle

RE: **AMERICARE HEARING - LANSING, MICHIGAN**
SEPTEMBER 6, 1991

Dear Senator Reigle:

In response to the request for written testimony relevant to the proposed provisions of S1227, I am presenting the following observations for your consideration:

- THERE IS A NEED TO PROVIDE ACCESS TO HEALTH CARE FOR ALL, BUT SOME OF THE ASSUMPTIONS UPON WHICH THE BILL IS BASED ARE INCORRECT.

  The 10% to 15% cost-shifting now billed to insured patients, offsetting the "free" care to the uninsured, is NOT going to become a 10% to 15% cost savings *after* Americare--the same "insureds" will be paying 15% to 20% more in taxes or loss of benefits to provide the program.

  Administrative costs of insurance companies are NOT excessive. Inside the "administrative costs" are inflation brakes.... large case management, surgical appropriateness and inpatient hospital certification services, mail order discount drug services, Employee Assistance Programs, Wellness programs... without whose services lower administrative costs soon become higher claims costs. Small business sees higher premiums in part because they are inclined to shop insurance prices every year (leaving behind insurance companies with high first year installation costs) until they exhaust the marketplace or are too sick to move. The insurance industry has failed to educate the buyer on what is available and how to buy it. For years commercial insurance carriers have offered medical contracts as a way to sell group life--no carrier is making a profit off of its group or individual medical insurance product.

The bill's sponsors believe that current provider reimbursement is uncontrolled. Actually, the health care providers have been strangled by audits, cost-containment, DRGs, Medicare cutbacks, Reasonable and Customary limits, PPO fixed pricing, discounts to insurance carriers for rapid payment returns... and still hospitals go bankrupt and doctors must diversify. Look at the low pay scale of the nursing profession in light of their skilled training and high stress responsibilities.

We pay more for health care in relation to other countries because we have unrealistic expectations of our health care system and we sue when our doctors don't achieve it.

- THE BILL LEAVES TO REGULATION CERTAIN FUNDAMENTAL FLAWS.

How will Americare coordinate with COBRA? Will it replace it? Will it follow it? What if the qualified beneficiary cannot afford COBRA?

How will taxpayers and businesses pay for Americare if they cannot afford the system we have? Ultimately, current plans will reduce benefits to a new minimum in order to afford compliance. The insured will then have extra out-of-pocket health costs in addition to increased personal taxes... unless, of course, we end up paying for Americare with a luxury tax or lottery.

What will prevent insurance companies from designing plans that will shift costs to the federal plan? What are the true effects of the cost-containment ideas that are, as yet, undefined and possibly unworkable (there is a large gap between the theories and the actual outcome of cost-containment measures)?

How are physicians' fees to be capped? Will the RBRVS guidelines be implemented? Who will pay and supervise the expansion of the federal staff needed to monitor the program, even if a workable way is found to have the states deliver it? One of the reasons that Medicare is an administrative failure, state Medicaid funds are bankrupt, and no one can decide how to provide standard health care across the board is that we want a simple solution to a complex problem--even assuming that insurance professionals are actually a part of the cost problem and their input into the solution an unnecessary confusion of the issues. The bill refers vaguely to consortiums of private insurance companies... will governmental regulators appreciate that bigger is NOT better? Will anyone involved in the insurance industry establish the regulations?

Who will determine the level of Americare benefits? The controversial issues? Experimental v. necessary care? Life-support to any length and at any cost?

- EVEN IF WE COULD FUND AND STAFF A NATIONAL PROGRAM, HOW COULD WE POSSIBLY IMPLEMENT IT WITHIN THE NEXT TWENTY YEARS... LET ALONE THE SIX YEARS THAT IS ANTICIPATED?

abs - THE COSTS OF THE FIRST SIX YEARS OF THE PLAN ARE OVERLY OPTIMISTIC.

The bottom line is that there will never be a way found to expand quality health care without deepening the recession and increasing the federal deficit.

As a Third Party Administrator, we manage self-funded medical plans for:

- small employers
- corporate plans
- Taft-Hartley union plans
- Multiple Employer Welfare Arrangements
- insured plans
- PPOs, HMOs, Section 125 plans

We are, therefore, deeply concerned that the cost savings that such self-funded plans have achieved through the use of professional claims administrators (TPAs)--the only *successes* in the health cost struggle--will be overlooked in the grand sweep of reform. Take a look first at what has succeeded and those instances where regulatory intervention actually contributed to the uninsured and the underinsured before you create a *"consortium"* of the *failures*.

Sincerely,

Gail Edwards-Bryant

Gail Edwards-Bryant
Director of Client Services

GEBsmk167

cc: F. Hunt, SPBA
A. Lapiana, President, ABS

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Fran Van Den Berg RDH, BS

Address: 1863 Townet Rd
Haslett, MI 48840

Representing: Have degree in Allied Health Ed

****

I invite you to attach a prepared statement or to submit your written testimony:

See attached :

Also: Interested in being locally active in helping get this legislation passed

Why do we take for granted that the cost of medical care is a real cost or an artificially inflated one.

Have you looked at physician incomes? If we balance cost of education and build in a reasonable work load, what should they earn in a year before we consider them sinfully over paid. Look especially at the charge for a surgery — gall bladder, for example. How many can one surgeon do in a day a week, a year. Would we get the same savings there as we realized when DRG's were instituted if we control fees that may be charged?

What about the cost of a visit at a physicians office. By allowing a new source of recovering costs, will physicians see the "help pockets that allow more billing for more services? (I talked with a physician for 1 minute about a television, and my insurance company was billed $35 for this minute) They rejected the claim because it was a pre-existing condition. Should I have waited until I could no longer walk? I couldn't afford this.

A look at the history of the charge would show that they were not gradually raised but artificially when there was a surplus of surgeons & they have short of work!

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Christine Cascaddan

Address: 240 Southlawn
E. Lansing MI 48823

Representing: Mich. Dental Hygienists Assoc

****

I invite you to attach a prepared statement or to submit your written testimony:

Along with a basic health care package other services are also necessary for minimum health care. Included in other services that belong in your package are: pharmacy, dental and other "special services" type care. Dental caries is still a prevalent disease in the poor and uninsured. Many people are forced to forego dental care because they can't afford it. Preventive services, along with the mandated water and other aids, can help decrease dental caries and other oral infections in the poor and uninsured.

The American Plan is designed to offer basic health care & I think that the basic package leaves out some other services that are now considered basic in other medical insurance packages. This bill is a step forward and am glad that this bill is starting to address the health care problem.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
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WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Deborah A Davis

Address: 911 C CHERRY LANE
E LANSING MI 48823

Representing: SELF

****

I invite you to attach a prepared statement or to submit your written testimony:

I SHOULD LIKE MD's & A.M.A TO NOT HAVE A MONOPOLY ON PROVIDER SERVICES FOR THIS HEALTH CARE INSURANCE.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Louis J. EYDE

Address: 46 60 S. HAGGERTY

Representing: EYDE CO.

****

I invite you to attach a prepared statement or to submit your written testimony:

THE PROBLEM IS THE PROVIDER

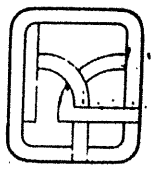
HOW DO WE CONTROL COSTS

(A) DOCTORS

(B) HOSPITALS

(C) SUPPLYS + EQUIP.

(D) DRUGS



HOSPITAL COUNCIL OF EAST CENTRAL MICHIGAN
141 Harrow Lane
Suite 11
Saginaw, Michigan 48603
(517) 792-1725

August 28, 1991

The Honorable Donald Reigle
United States Senate
Rm. 105 Dirksen
Senate Office Building
Washington DC 20510

Dear Senator Reigle:

I am looking forward to attending the Finance Subcommittee Hearing on S.1227, "Health America". on September 6. I have had the opportunity to meet with your staff assistant, Lawrence Whiteside, to review the intent and scope of proposed legislation; Mr. Whiteside has been helpful.

We support legislative initiatives which seek to integrate private and public sector priorities when addressing access and affordability of health care services. There should be appropriate incentive for business to participate in expanding insurance coverage for working Americans; however, there may be limited utility to mandating coverage requirements.

The Hospital Council is contributing to reform dialogue by actively working to identify and implement health care access and employee benefit management strategies which will be beneficial to providers and business. This year we conducted a Survey of nearly 900 of our region's businesses. The results will be used to support a Blue Ribbon Committee, which is being convened to constructively work towards formation of practical solutions. Elements of S.1227 will surely be incorporated into our considerations, of which we will keep you informed.

We appreciate your mindful consideration and support of legislation which is aimed at the uninsured crisis. We will remain active in our support of legislation which improves access to health care services, and that represents fair and equitable treatment of hospitals.

Thank you for your consideration.

Respectfully,

RANDOLPH K. FLECHSIG
President

c: D. Chang
RKF/mk

Michigan State University

Leonard M. Fleck, PH.D.
Associate Professor of Medical Humanities
Medical Ethics and Health Policy

C-201 East Fee Hall
East Lansing, Michigan 48824-1316
(517) 355-7550

EAST LANSING • MICHIGAN • 48824-1316

September 6, 1991

TO: Senator Donald W. Riegle, Jr.
Senate Finance Subcommittee on Health
for Families and the Uninsured

FROM: Leonard M. Fleck, Ph.D.
Center for Ethics and Humanities in the Life Sciences
Michigan State University

RE: Testimony for September 6 Hearing at the Kellogg Center

I would like to take this opportunity to call your attention to an important community education project that I believe is germane to the work of your committee. The project is titled "Just Caring: Conflicting Rights, Uncertain Responsibilities" [Citizen Forums for Health Care Reform]. The basic premises of the project are: (1)that there is need for substantial reform of our health care system, that patchwork reform is costly, inefficient and inequitable; (2)that health care is a moral good, not just another consumer good to be distributed in accord with ability to pay, and hence, that there are issues of justice that need to be addressed with regard to health care policy; but (3) we cannot, even as a wealthy society, afford all the health care that might be desirable or technologically possible, and hence, we have to make some hard choices about limits and priorities regarding health care spending; and (4)such choices ought to be public and visible, and ought to be a product of broad public dialogue---sustained, comprehensive, respectful, structured, rational public dialogue aimed at achieving some consensus regarding limits and priorities for health care spending, a consensus that reflects a commitment to both equity and efficiency. Oregon has offered America one version of what such a dialogue might look like. Michigan, through the "Just Caring" project, can offer an alternative version.

What the "Just Caring" project rejects is the idea that there is some simple or magical solution that can be responsive to the problem of health care reform, a solution that relies upon clever economic or organizational or managerial strategies for containing health care costs. Those approaches can be practically useful only after there is broad and stable societal agreement about what counts as a just distribution of health care in our society. That kind of societal agreement is what is lacking now, and that lack results in all manner of cost shifting in health care as various payors deny responsibility for meeting the health needs of the poor, the uninsured, and the uninsurable. The "Just Caring" project would create throughout the state of Michigan democratic forums for forging a consensus about what health reforms ought to be undertaken in order to achieve a fairer and more affordable health care system. This is a project that will take place over the next three years, which is a long time in political terms, but which is absolutely necessary if we are to get beyond simplistic exchanges of ideological slogans about health care.

Attached is a six-page description of the project in its current form. Also attached is a 42-page paper that describes the project is greater detail, along with a more detailed explanation of the rationale behind the project. This paper will be a chapter in a forthcoming book titled Health Care Policy Reform: What the States Can Do. We will certainly keep you apprised of this project as it evolves. More importantly, we hope that you and your staff might be actively involved in this approach. The conference that will launch this project will occur on December 5 at the Kellogg Center, Michigan State University.

MICHIGAN STATE UNIVERSITY

THE CENTER FOR ETHICS AND HUMANITIES
IN THE LIFE SCIENCES
C-201 EAST FEE HALL
TELEPHONE (517) 355-7550

EAST LANSING • MICHIGAN • 48824-1316

JUST CARING: JUSTICE, HEALTH CARE AND THE GOOD SOCIETY

Project Rationale

Most Americans are morally troubled by the idea that whether an individual lived or died would depend upon whether they could personally afford to pay for the health care that would save their life. There would seem to be even more agreement that we ought not to just auction off to the highest bidder hearts and livers that become available for transplant purposes. These are not just personal biases or collective moral prejudices. These are products of well-reasoned moral thinking in our society about justice. These kinds of shared considered moral judgments do not often get articulated in our public discourse. But I would want to argue that they provide the natural starting points for public moral conversations about such issues as justice and health care policy; and further, they suggest that such conversations can be productive of more such consensus regarding matters of justice in the future.

Anyone familiar with the problems of health care in America over the past ten years knows that there has been a growing number of individuals who have difficulty securing access to needed health care [the equity problem] and that the cost of health care has been escalating at roughly twice the rate of inflation as measured by the CPI for at least fifteen years [the efficiency/ cost containment/ consumer demand problem]. More precisely, total health expenditures in 1990 in the United States were about $660 billion or about 12.2% of GNP. That can be compared to the $26 billion we spent on health care in 1960, which was then 5.2% of GNP. And yet there are 37 million Americans without health insurance. The two problems are directly related to one another in that escalating health costs have compelled decisionmakers in both the public and private sectors to reduce the number of people covered by health insurance as well as compromise the quality of the coverage itself. Our public life would be a lot simpler if there were obvious villains who could be identified, like industrial polluters. But the "villains" in health care are all those researchers and physicians who produce amazing, but costly, technological breakthroughs that are the source of tremendous health benefits from which we all potentially benefit. This is what really creates a most painful problem for public discourse.

The technological advances we take as visible and powerful evidence of the superiority of our health care system carry a very high price tag in both economic and moral terms. In Kansas City the father of twin five-year old girls was told that he would have to come up with $260,000 for the bone marrow transplants that might save the lives of his children. [His employer's insurance company had gone bankrupt months earlier.] Should a just and decent and caring society allow such things to happen?

One of the painful features of the way in which our society has chosen to finance health care is that those with the greatest health needs are least likely to have the health insurance that will assure their access to adequate health care. This will become painfully evident as the "baby boom" generation ages out.

Currently the elderly have 3.5 times the health needs of the non-elderly. They make up 12% of the US population now but account for 34% of all health spending per year, about $230 billion in 1990. And by the year 2030 the elderly will represent 20% of the US population. The potential problems there are ominous. As a society we must ask ourselves what kind of health care and what level of health care we are morally obligated to provide to the poor, the sick elderly, the catastrophically and chronically ill,

the terminally ill, infants severely impaired at birth, and so on. Is it just that access to health care should be determined by ability to pay? Does justice require that we have a system of health insurance that covers everyone? And if we did have such a system, given the need to contain costs, how would we make rationing decisions fairly?

How can any politician, how can any sensitive citizen, stand up before their neighbors and friends and family and say that we ought to deny heart transplants (or some other expensive life-prolonging medical intervention) to those over the age of 70? Yet this is exactly one of the issues that we must address as a society---publicly, visibly, rationally, sensitively, and fairly. This is the issue of health care rationing, a fact that many in our society would prefer not to acknowledge. But by failing to address such difficult and divisive matters in public forums we silently endorse the invisible forms of rationing that gradually expand the ranks of the uninsured and that dilute the quality and adequacy of health care to those dependent upon Medicaid or other publicly funded programs. That kind of invisible rationing has nothing to recommend it from the perspective of justice since it allows all forms of invidious discrimination to operate unchecked and unchallenged.

Numerous national and state organizations have endorsed the idea of a process of public education and dialogue that would address these issues. Oregon has provided one model of what such public discussions might look like. We would like to try a different approach. Len Fleck has written a concept paper in which he outlined what such an alternative statewide project might look like. The project presented in that paper is outlined below. What would be distinctive of this project is that it would create public forums around the state of Michigan for addressing these issues <u>as issues of justice</u>, not simply as issues that can be resolved through the application of economic or organizational or technological expertise. At bottom there are value questions that need to be addressed. They have to do with the basic values to which we are ultimately committed and that define the character of our society, the extent to which we are in practice a just and caring community. As a society we need to address the issue of <u>limits</u> in health care as well as the issue of <u>priority setting</u> with respect to meeting health needs. And the framework within which this must occur is the framework of justice and equal respect for the rights of all. In addition, there are the values of individual liberty and commitment to scientific innovation that are also part of the overall value equation.

<u>Basic Project Description</u>

We recognize the complexity of the issues that need to be addressed. Hence, it is not sufficient to have one or two-day conferences around the state to discuss these issues as a primary tool of public education. There needs to be a comprehensive public conversation about these matters, a sustained public conversation that has depth and direction, a conversation in which there is a commitment to the methods of reason and critical analysis (as opposed to having citizens hurl simplistic slogans at one another), a conversation in which we integrate our social value judgments regarding health care policy with our best scientific and economic information regarding health care and health care policy options. Further, this is a conversation that has to be highly visible in order to have the broad educative effects that are ultimately necessary to effect policy reform.

We are proposing, therefore, that there be twenty sites around the state where these conversations would be formally organized, five of which would be in the Detroit metropolitan area. Over a two-year period of time [calendar 1992 and 1993] there would be approximately 25 "seminars" or workshops or focussed citizen conversations that would occur at each of these sites. While all of these workshops would be open to the public, there would be approximately 50 formal workshop participants at each site who would be broadly representative of that local community, but who

would be the opinion leaders of that community. This is obviously a very large project, but a project of this magnitude is needed to attract the media attention that would stimulate more informal public conversation of these issues beyond the limited number of individuals who will be participants in the formal seminars or workshops.

We cannot emphasize too strongly the complexity of the task we face as a society in choosing health policies that are feasible, fair, and efficient. There will be difficult and painful trade-offs that will have to be made. This is what health care rationing requires. The project is designed to take place over a two-year period of time because it will take that long for participants to struggle with the task of thinking through and talking through these trade-offs with one another. Also, this is an educational project. Our expectation is that project participants will do a substantial amount of reading so that their conversations have greater depth and substance. Also, we realize that there are powerful interest groups that shape health policy currently. We hope to provide "neutral forums" in which the skewing and distortive effects of interest groups on policy conversations can be muted. We have been successful in designing forums like this in the past.

Project Sponsorship

This project has already been initiated with the help of a small grant from the Kellogg Foundation through Michigan State University. At present the Center for Ethics and Humanities in the Life Sciences [MSU], the Office of Medical Education Research and Development [MSU], and the Medical Ethics Resource Network of Michigan are the sponsoring institutions. But over the next several months we expect to involve virtually all the major statewide health organizations in this project [Michigan Hospital Association, Michigan State Medical Society, Michigan Nurses Association, various agencies of state government, etc.], academics from all the major universities in Michigan, representatives from both the business community and organized labor, and major social service agencies in the state. We also expect that community colleges in the state will be closely connected with the project since it is most likely that they will provide the natural community sites for the project.

Project Objectives

(1) To create public forums in which health care professionals and thoughtful citizens can engage in a sustained and systematic discussion of critical moral issues raised by changes in health care technology, health care delivery, health care financing, and health care policy.

(2) To raise the overall level of awareness and understanding of these moral and political issues throughout the state through the judicious use of local newspapers and television, recognizing that only a limited number of people can engage in the face-to-face conversations envisioned under Objective #1.

(3) To identify and assess from a predominantly moral perspective, specifically the perspective of justice, policy options at the institutional, community, state, and national levels regarding moral issues raised by changes in health care technology, financing, and delivery mechanisms.

(4) To identify as clearly and precisely as possible those "considered moral judgments" of justice that can serve as shared starting points for our moral conversations that will have to address more controversial moral issues connected with health care policy.

(5) To develop a richly nuanced and realistic moral conversation at the state and community levels, one that is both sensitive to the political, economic, and institutional constraints

that makes "perfect justice" impossible, and that balances what are sometimes several legitimate moral values in conflict with one another.

(6) To create institutionalized state and community linkages that will assure the sustaining of this conversation after the project has been completed, in particular, linkages between an informed lay public and institutional providers of health care.

Project Timetable

There will be four phases to this project. The first will be an organizational phase lasting 12 months during which project resource materials will be developed, a project advisory board put in place, faculty will be identified, project participants will be identified at each site, faculty at each site will be trained, the media will be apprised of the project, and the money will be raised to finance the project. We estimate total project costs of about one million dollars. We estimate the project will cost about $35,000 per site, and our hope is that local foundations at each site will "adopt" the project. Central project costs will be about $300,000. Besides five project sites in metropolitan Detroit, the other most likely sites are Ann Arbor, Battle Creek, Kalamazoo, Flint, Lansing, Grand Rapids, Saginaw, Midland, Mt.Pleasant, Cadillac or Grayling, Escanaba, Marquette, Traverse City, Benton Harbor-St Joseph, Petoskey, possibly Port Huron.

The second phase of the project will take place over the course of a year. This will be the problem identification and analysis phase of the project. The third phase of the project would be a value integration/ value trade-off phase of the project, roughly six months in duration. Here we would try to develop a universal health financing policy that was equitable and affordable. Specifically, we would establish priorities among competing health needs. The fourth phase of the project would be a summative/ integrative phase. We would hold some sort of "health parliament" with delegates from each of the twenty project sites.

We recognize that the problems we hope to address through this project are complex and sensitive matters, and that it will probably take many years for us as a society to work through the problems of fair and efficient resource allocation and financing with regard to health care. But a well managed project like this can move along that process of public understanding substantially. We live in what political scientists describe as a liberal, pluralistic, tolerant, democratic society. To sustain such a society, most especially when we are faced with deep value conflicts and confusions, as in the arena of health policy today, requires a commitment to public reason that is manifested in public conversations. Through this project we hope to create a model of what such public reason can be, a model that we hope will be more widely adopted in our society, and that we see as necessary to sustaining any civil democratic society.

Finally, the "home" for this project is the Center for Ethics and Humanities in the Life Sciences at Michigan State University. In some respects this is an accident of where the project directors have their academic appointments. But in other respects this a natural home for a project such as this. The core group of project organizers have considered a number of alternatives, but the virtue of university-based sponsorship is that of having a forum wherein "neutral conversation" can occur, public conversation that is not excessively skewed by ideological biases or interest group politics. Our universities represent the primary institutional foci through which we create public reason. All of the faculty who are involved in the organization of this project have previously been involved in extensive community education efforts. They are skillful in facilitating reasoned public conversation about controversial matters. We expect these same skills in all the faculty who are involved at each local project site.

Leonard M. Fleck, Ph.D.
Center for Ethics and Humanities
in the Life Sciences
Michigan State University

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Evelyn T. Gladney

Address: 738 Sparrow Ave
Lansing, Mi 48910

Representing: C.A.C.S Pre-School / Head Start Prog

****

I invite you to attach a prepared statement or to submit your written testimony:

As health coordinator I am responsible for seeing that each child in our program receive a complete health and dental exam. Last yr we (H.S.) spent over $17,000 on <500 children because they had no insurance for health or dental and had no Medicaid coverage. Since May 91 many Medicaid Services are now closed and not a Pedo dontist in the Lansing area will accept Medicaid. This is pitiful!

March of Dimes
Birth Defects Foundation
Southeast Michigan Chapter
17117 W. Nine Mile Road
Suite 820
Southfield, MI 48075
Telephone (313) 423-3200

Chapter Officers
Dennis J. Flynn, Chapter Chp
John G. Marshall Vice Chp
L. Brooks Patterson Vice Chp
John M. Serhal, Treasurer
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Cathy Stelhn
* John A. Thompson
Stephen K. Valentine, Jr.
* Anthony J. Viviano
* Craig P. Warburton

Thomas A. Ruopelle, Chapter Director

* Executive Committee

September 5, 1991

The Honorable Donald Riegle
105 Dirksen Senate Office Bldg.
Washington, D. C. 20510

Dear Senator Riegle:

On behalf of the Michigan Chapters of the March of Dimes, the Michigan Council of Maternal and Child Health and Healthy Mothers, Healthy Babies, Michigan Coalition, I applaud your efforts to make health care available to all Americans, focusing on children as a priority.

These groups would hope that the ultimate document will address preventive programs and in particular prenatal care as priorities as well. We especially endorse the intent to remove health care from the Medicaid/Welfare program. This will serve to encourage citizens in need to take advantage of health care services.

Thank you for your leadership and continued efforts to make health care accessible not only to mothers and infants, but to all citizens.

Sincerely,

Mary Ellen Gleeson, M.S.N., R.N.
Director of Community Services

Chair, Michigan Council for Maternal and Child Health

Healthy Mothers, Healthy Babies Steering Committee

MEG/raw

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Emerald Gonzalez

Address: 810 Larkspur Drive
E. Lansing Mi 48823 (351-9414)

Representing: Self - educational (I am interested in help in this project please me if I can be of any help to you.)

I invite you to attach a prepared statement or to submit your written testimony:

I am presently known as professional medical manage of billing and collection (All health insurance) Accounts for Health professions. And I have consciously (bec. Health problem) decided to change my business career to Bio-Ethics and support to universal Health access. Being biller and collection person has help me create awareness zeal to help correct this genesis that is affecting us all. We/people (providers) don't choose to get sick and in top of that how dare we profit in the healing that is a gift of life that has been honored to (us) all We need to emphasize universal preventative health and health insurance for all. Let's change this health system upside down by providing universal health to all and that government be charge of this project rather arms race weapons then on

It is not easy to collect money from Reg. that doesn't have money for health this is unethic and morally wrong.

~~test~~

I ~~testify~~ that providers do and can charge outrageous charges may it be clinical or testing through aid of ~~technology~~. And that pesons like myself billers/collector attempt to collect these billes no matter what situation the patient maight be presented with.

Only an assertive (tangacious) person (like myself can talk the providers to writing off the accounts because the account is a dead beat. And this is not easy yet it is importan [redacted] to make the distinction on wheather the account will paid by patient or not rather letting this account carryon on the accounts receivable.

I also testify that all of the providers I worked a people that believe in given care with out reservation. But still someone must pay for this risk taken desion; eighter patient pockets or business facility lack of management

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
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United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: ROBERT HAPEMAN

Address: 1943 BIRCHWOOD
OKEMOS, Mich. 48864

Representing: Self

****

I invite you to attach a prepared statement or to submit your written testimony:
After hearing the first group of testimony, I have concerns regarding the inflationary impact if the plan were implemented without a "lead time" for the medical providers to prepare for a 10% or more increase in demand for services from people who currently are denied service or voluntarily restrict their own care for lack of insurance.

If demand for service is increased without increasing (the number of) suppliers, the suppliers will charge more. We heard testimony from individuals

that didn't go for medical care when they should have, and from a doctor that says the number of obstetricians in Michigan has decreased over 50% in the last few years. We know there is a severe shortage of nurses. If the demand becomes greater, either all patient will receive a little less service or some patients will still be denied services in favor of those patients with insurance that pays higher rates;

If students knew demand for medical services would increase after, for example, 5 years due to your bill and malpractise insurance, reimbursement rates and other deterrents would be removed at the same time, then perhaps we could graduate enough doctors and nurses to offset the increased demand for services and keep inflationary effects to a minimum.

Thank You

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA: AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: D. Borta Hiscoe MD.

Address: 1817 Walnut Hgts Drive
East Lansing, Mich 48823

Representing: Retired Surg, 40 Med Dir, amer Bcn CHM - and - Hiscoe Associates - consulting

****

I invite you to attach a prepared statement or to submit your written testimony:

Med - Community Rating would help level the field,
" - Incentives to encourage Physicians to go into group Practice.
Best is Competing systems of managed care introduces accountability & discourages micromanagement by govt. Can look at outcomes primarily.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
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United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: John Hoyle *

Address: 1945 Pauline Suite 11
Ann Arbor, MI 48103

Representing: Washtenaw Associates for Community Advocacy

****

I invite you to attach a prepared statement or to submit your written testimony:

As an organization and personally this effort is to be applauded. — If, as should be expected, further compromises are necessary in the pursuit of enacting meaningful reform, PLEASE do not compromise universal access. No measure can claim to be decent or to afford quality unless it assures equal access, regardless of financial, employment or any other status including disability or age. — THANK YOU!

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
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United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: Chris Hunter

Address: ~~[redacted]~~ Dept Labor PO 30015
Lansing 48909

Representing: Division on Deafness

****

I invite you to attach a prepared statement or to submit your written testimony:

I support this bill. It needs one addition: Coverage for interpreter services used by deaf persons in doctor's office and hospitals. Even though Michigan & Federal Civil rights laws require interpreters, many times the doctors/hosp administrator try to avoid it. If deaf person or doctor or nurse misunderstands the message, it can drive up the health care costs. It happened often. over-

If you need to contact me—
my number is 517-373-0378
TDD or Voice.
Thank you for your support!

Hearing 9/6/91

Please add these comments to the bill S.1227

The coverage for mental health care is insufficient in light of our national need to provide mental health care to prevent crime, homelessness, drug, abuse, and other social problems, including alcohol addiction.

Why discriminate against a large portion of our citizens for a health problem which usually does not involve the large costs of other health care, i.e., surgery and expensive equipment, etc. Not only is coverage for care as described in your summary of S.1227 delimited to visits per year as opposed to dollar amounts for other forms of health care, but a 50% co-payment charge for mental health care and 20% for other health care is discriminatory.

I am concerned as an employee for over 10 years in the mental health field.

Janet R. James, 4537 Hawthorne, Okemos, Mi 48864

Rochester Sales, Inc.

1126 N MAIN STREET • ROCHESTER, MICHIGAN 48307 TELEPHONE 313-652-0033 • FACSIMILE 313-652-0040

September 1, 1991

Honorable Senator Riegle, Jr.
United States Senate
Washington, D.C 20510-2201

Subject: Lansing Hearing Regarding S.1227 "Health America"

Dear Senator Riegle:

Our company is very concerned with the runaway costs of medical care. We appreciate this opportunity to participate in your hearing on September 6, 1991 in Lansing, MI.

We submit the following positions after discussing and polling fellow small business associates:

1. Health care costs must be controlled and insurance claims have a direct bearing on the increased burden to policy holders and malpractice insurance costs.

2. American's deserve the best health care, this is a privilege and not a constitutional right. Minimal care should be provided. However, free services are often exploited and a socialized plan will only have a downward affect on the quality of care.

Canadians seek increased, unnecessary services and more multiple opinions because it is free. Workers compensation claims would increase because employes would visit as many doctors as possible until someone sided with a fraudulent claim.

Our company looks at the full benefits we provide as an enticement to work for us. Why don't other employers compete for the best employes by offering full benefits?

One of the largest criteria my girlfriend seeks in a potential employer is full Blue Cross coverage. She won't settle for less.

3. Blanketed plans like Medicaid have failed because the government can't administer and regulate on such a large scale. Elderly care facilities are a prime example of exploitation of a poorly administered system.

4. Costs for medical services should be reviewed in terms of relative value. Since consumers can't truly shop, nor have an incentive to find the best services at the lowest cost, government must regulate and assess relative costs. Removal of a wart should not constitute surgery and dermatological costs are unfairly billed to insurance carriers. I'm sure this isn't the only field worth evaluating.

5. This issue of insurance abuse is pervasive in our litigious society, but nonetheless requires attention. Costs have spiraled upward because of fraudulent claims and lawsuits.

6. If a system must be invoked, patient/physician relationships must be allowed to occur. PPO's are failing to some degree because doctors don't know their patients and symptoms get overlooked.

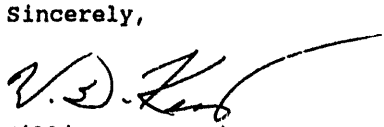
7. Malpractice insurance has driven some of the best physicians to HMO's and PPO's to limit personal exposure to lawsuits. Shouldn't this be our focus, reducing runaway costs so the system can be affordable for everyone?

Government is responsible to protect individual rights granted by the Bill of Rights and the Constitution. Social programs have a poor track record for elevating the lowest members of our society. I volunteer hundreds of hours each year working as a Crisis Center Intervention Specialist (I answer phone and face to face crisis calls), these are the trenches were welfare programs and medicare can be seen first hand.

I, and many others believe that everyone needs some motivation to elevate themselves. Some people hit rock bottom earlier and can react better than others. Some don't know how. We are attempting to teach those how. If there is no reason to strive, because government provides minimal sustenance, then we will only be suppressing these individuals into a permanent poverty blackhole.

If someone is feeding me, caring for me and providing for my basic needs - **WHY TRY?**

Sincerely,



William D. Kennis
Vice President

cc. Congressman Broomfield

Mr Walter Kosciorzynski
32329 Beacon Ln
Fraser MI 48026

27-1-4942

Aug. 30, 1991.

Dear Senator Riegle,

I had to respond to your newsletter telling us about the hearings you will be having in regards to "Health America."

My husband is currently unemployed. He was an engineer for Creative Industries. He was layed off on March 15th and has been unable to find another position. Because of Walter's lay-off we have to pay for our own health insurance. Since it has been almost six months of no work plus the expense of health insurance our savings and our peace of mind are nearly depleted.

I don't feel that the greatest country in the world, the United States, can care for it's own citizens. If you're an American, you should feel secure enough to know that you will be able to seek medical attention if necessary.

We are not alone in our feelings. There are millions of Americans who through no fault of their own are not covered by any health insurance. We hope you are able to get S. 1227 ("Health America") passed. Help us Senator Riegle.

Sincerely,
Karen Kosciuszynski
Walter Kosciuszynski
32329 Beacon Lane
Fraser, Mi. 48026

The United Way
500 Commerce Building
Grand Rapids MI 49503 3165
616-459-6281
FAX 616 459-8460

September 6, 1991

The Honorable Senator Donald W. Riegle
Western Michigan Regional Office
Suite 716 Federal Bldg.
110 Michigan Avenue NW
Grand Rapids, MI 49503

Dear Senator Riegle:

The United Way would like to thank you for this opportunity to provide written testimony to the Senate Finance Subcommittee on Health for Families and the Uninsured for Senate legislation S1227 entitled "Health America."

The United Way is a strong local advocate and is considerably involved in decision-making activities which address community health issues.

Western Michigan and its major metropolitan area Grand Rapids have a wide range of health services, but is no different from the rest of the nation in the problems associated with inadequate access to health care. This lack of access for health care services is evident in our population by race, income, and gender. Since individuals and families experience barriers to services, they are unable to seek equitable care on anything but an emergency basis. This trend has resulted in problems for our local hospital emergency rooms. The four local hospital emergency rooms in Grand Rapids reported a combined total of more than 3.5 million in unpaid charges last year. Many of those persons did not have health insurance and this figure does not even realize the number of people who are turned away or do not seek services.

Locally, barriers to services other than not having adequate insurance coverage include the inability to secure transportation for services and to pay out-of-pocket costs for even minor care. Based on local surveys of need, racial/ethnic minorities and children are overall the most affected by access problems. Care facilities also report seeing an increase in the number of working poor families entering the system. These families are often without adequate health care benefits since they work for small employers.

"First Call For Help," an information and referral service provided by The United Way and the Kent County Department of Social Services has seen increases in certain health calls from the community. When comparing year-to-date figures of July 1990 and July 1991 the following increases were reported:

Medical Care	111.5%
Dental Services	76.4%
Health Supportive Services	76.7%
Health Insurance	94.4%
Health Financial Assistance	20.7%

Health needs continue to increase in this community and equal access to health care services is an important issue that demands attention. Our organization is always interested in working in partnership with government programs and have traditionally provided match funding for many programs developed with state and federal funding.

Once again, thank you for this opportunity to provide written testimony. The United Way will continue to provide information as needed.

Sincerely,

Wendy S. Lewis, M.S.W.
Senior Associate
The United Way

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Rhonda Maney

Address: 3776 Birch Row
East Lansing Mi 48823

Representing: _____

****

I invite you to attach a prepared statement or to submit your written testimony:

I am a 2nd yr Medical Student at MSU. I am 36 years old, and a single parent, and find myself in the precarious position of trying to finance my education @ a reasonable rate, as well as be a good student and parent, and the sole way earner for my family. As I study to become a physician, I am myself without health insurance for myself or daughter, and am thus without access to health care. Even though I fall within the category of single parent w/ dependents, I am not eligible for Medicaid because I am in a graduate program of study - It is

their opinion that I should quit school + work to provide my own coverage.

My struggle encompasses more than lack of insurance which is very worrisome. It also magnifies the priorities of this country. Clearly, educating and providing health care to our citizens is not one of those priorities as is evidenced by the dearth of affordable school loan programs and the total lack of grant monies available for education on a graduate level.

I support your efforts to bring about a more equitable program of health care

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: Lois Matthews

Address: 622 Moorland Dr.
East Lansing, Mi 48823

Representing: myself

****

I invite you to attach a prepared statement or to submit your written testimony:

I am an individual who was diagnosed with M.S. several years ago. I am employed full time and fortunately still have health benefits. I do not know how long I'll have this job, and if I change employers, I would possibly be uninsurable. I would prefer that the U.S. turn to a health care system similar to Canada's. My second choice would be one similar to Germany's. The Americare plan is a step in the right direction, but is too little too late for many people.

MICHIGAN REGIONAL OFFICES

TESTIMONY OF
NANCY MCKEAGUE, DIRECTOR OF GOVERNMENT RELATIONS
MICHIGAN CHAMBER OF COMMERCE
BEFORE U.S. SENATOR DONALD W. RIEGLE, JR.
CHAIRMAN, SENATE FINANCE SUBCOMMITTEE ON
HEALTH CARE FOR FAMILIES AND THE UNINSURED
RELATING TO
S. 1227
LANSING, MICHIGAN

FRIDAY, SEPTEMBER 6, 1991

Senator Riegle and members of the Subcommittee, I am submitting the following testimony relating to S. 1227 on behalf of the 6,200 job provider members of the Michigan Chamber of Commerce. Our members are of diverse type and size, with the majority employing 100 or fewer persons.

There is no question that Michigan, and the nation, face a health care crisis of great magnitude. The business community shares your concern about escalating insurance costs, over-utilization, and the number of citizens who are uninsured.

The Michigan Chamber, through its Health Policy Committee, has spent a substantial amount of time over the past year studying the issue of health insurance and developing priorities for addressing the concerns pertaining to quality of care, access to care, and health care cost containment.

We are proud that 76 percent of Michigan's insured citizens are protected by an employer-provided health benefit plan. We believe Michigan's job providers have been responsible participants in establishing a network of coverage which cares for our employees and their families today -- over two-thirds of the state's uninsured population in total. Yet provision of these benefits has become an increasing burden for business. Large and repeated increases in the cost of health insurance have made it difficult for employers to foot the whole bill, and have made it impossible for some companies to offer health care benefits at all.

Senator Riegle, your letter announcing this public hearing said, in part, "This bill will also help American businesses. Companies that now provide health insurance have experienced huge rate increases because they are paying indirectly for the medical care of uninsured people." The only real change brought about by S. 1227 is that businesses would pay directly for the care of the uninsured.

Requiring all businesses to either provide health insurance to employees or pay a tax to a public program for the uninsured does nothing to solve the underlying problems contributing to the high cost of health insurance. This tax, estimated to amount to nearly eight percent of payroll, merely shifts the responsibility for the provision and funding of health insurance to business.

According to a national survey conducted by Foster, Higgins and Company of New York, spending on health care increased 21.6 percent during 1990. On average, the survey found, employers spent $3,161 per employee on medical costs last year -- $561 above the 1989 cost. If these costs continue to rise at the current rate, the annual cost to provide medical benefits to a single employee will reach $22,000 by the year 2000. Perhaps most telling are the results of the Alexander & Alexander 1991 National Risk Management survey. Asked to rank the 15 areas with the highest level of importance, 80 percent of the businesses responding listed spiraling health care costs.

As costs have increased, the number of employees with fully paid health premiums has declined, and co-payments and higher deductibles have become common. According to the U.S. Labor Department, 75 percent of employees had fully paid individual health care premiums in 1982. By 1989, the percentage had fallen to 48 percent. Though Foster, Higgins said that "cost sharing has proved to be the only cost-management technique to yield significant savings in traditional health insurance

coverage", it has also sparked many labor-management disputes. In 1989, 78 percent of all strikes were provided by controversy over health care costs.

State mandates on health insurance, requiring specific types of coverage and the extent of such coverage, have also contributed to this cost escalation. This discourages small employers from providing health benefits and places a steadily increasing burden on those who have plans in place. According to a recent survey of small businesses, 16 percent of those not offering plans to their employees would offer benefits in a less heavily mandated setting. Fully, 50 percent of the large firms converting to self-insurance did so to escape state mandates for group insurance.

For example, Michigan requires that group health insurance policies provide coverage for drug abuse treatment. While such coverage is certainly desirable, the Health Insurance Association of America (HIAA) reports that chemical dependency treatment coverage increased premiums by 8.8 percent. The HIAA also reported survey results showing that 51 percent of the large firms converting to self-insurance did so to escape state mandates for group insurance.

S. 1227 recognizes the cost of mandated benefits by establishing a basic benefit package, focusing on preventive and emergency care.

Business owners recognize the need for change in the health care system in order to control costs, while still providing needed health benefits.

In a poll conducted by Fortune magazine (May 7-16/Clark Martire & Bartolomeo), chief executive officers from Fortune 500 companies showed their concern in responding to the following questions:

Q. Some employers believe the rising expense of health insurance will be their greatest cost problem in the 1990s. Do you agree or disagree?

A.
Agree, one of the greatest problems.....63%
Agree, the greatest problem.....35%
Disagree.....1%
Not sure.....1%

Q. Given problems such as the rising cost of health care and the more than 30 million Americans who remain uninsured, should the U.S. adopt a nationalized health care system, financed by taxpayers?

A.
Yes.....24%
No.....69%
Not sure.....7%

Q. At what rate do you expect health care costs per employee to climb at your company over the next five years? An annual rate of...

A.
Less than 5%.....2%
5% to 10%.....29%
11% to 15%.....46%
16% to 20%.....19%
More than 20%.....3%
Not sure.....1%

Q. Costs aside, are you generally satisfied with the quality of health care your employees receive?

A.
Yes.....95%
No.....4%
Not sure.....1%

Q. Of the following factors, which two or three do you consider the most important when it comes to driving up the cost of health insurance for U.S. companies?

A.
Liability awards and malpractice insurance.....79%
Expensive new technology.....59%
Unnecessary surgery and other procedures.....52%
Inefficient hospitals.....28%
Excessive paperwork.....27%
Overuse of other benefits by employees.....23%
Overpaid doctors.....22%
Overuse of mental health benefits.....17%
Other.....12%

According to the U.S. Chamber of Commerce, corporations already pay out 67 percent of revenues in employee compensation. Adding another eight percent tax would mean the failure of struggling enterprises and wide-spread workforce reductions.

The stated goal of reducing current uncompensated care cost shifting is admirable. But cost shifting is not accomplished by moving to universal coverage when America's job providers are forced to pick up the

tab. It simply means higher costs for business while allowing Congress and the state legislatures to ignore the reforms which are necessary to make a real and lasting impact on our health care delivery system. Worse, this proposal begins implementing the employer requirements while the elements referred to as costs savings are "researched", "developed" and "assessed". All of us who work in or with government know the results would not be seen for many years -- or not at all.

This proposal is silent on medical liability reform, but for a reference to practice guidelines. It does not address the issue of access to care and may, in fact, impair access to the extent it relies upon provider fee schedules for services rendered. It establishes yet another bureaucracy, the Federal Health Expenditure Board, to coordinate with an all-new state bureaucracy, the state purchasing consortia, in order to negotiate payments and publish data on providers. Because both of these functions would apparently rely upon increased reporting, it is clear that whatever administrative savings there might be from standard forms would quickly be erased by the cost of data collection and funding for these new entities.

The proposal also discusses some exemptions for small business, "more favorable tax treatment for the self-employed", and an exemption for new businesses. While those provisions may well be laudatory, they increase the already unacceptable cost of the program overall.

Your Executive Summary estimates the cost of the "Health America" coverage at $1,680 per worker. An employee contribution of 20 percent, or $336 would be required. Yet our experience as employers shows that workers often will elect not to accept employer-sponsored health benefits if a co-pay is mandatory. This is especially true of young and/or entry-level employees.

Most troubling is the closing paragraph of your Executive Summary, which reads as follows: "The cost to the federal government in the first year of the plan will be $8 billion. A program of financing will be developed before this plan comes to the floor to assure that it does not add to the Federal budget deficit."

As job providers struggle to continue operations during tough economic times, that statement is not sufficient. The combined issues of health care and the federal deficit are too important for any of us to accept vague promises.

The Michigan Chamber's legislative priorities relating to health care are attached for your review. We strongly believe a comprehensive approach to health care cost containment, including medical liability reform, is necessary to achieve the goals of reducing costs and improving quality and access.

S. 1227 recognizes some of the problems we confront but makes two mistakes; it penalizes employers, jeopardizing jobs and it stops short of comprehensive reform.

Mental Health Association in Michigan™

Gordon L. Steinhauer
President
Tom M. Sovine
Executive Director

TESTIMONY SUBMITTED TO THE
SENATE FINANCE SUBCOMMITTEE ON HEALTH FOR
FAMILIES AND THE UNINSURED
SEPTEMBER 1991

The following testimony is presented on behalf of the Mental Health Association in Michigan a non-partisan, non-governmental organization representing a broad base of people working together to advocate for improved care and treatment of the mentally ill, the prevention of mental illness and the promotion of positive mental health.

We are pleased that the Senate Finance Subcommittee has been formed to address the problem of the huge number of uninsured, people who have no protection against the cost of physical or mental illness.

The Mental Health Association in Michigan and other advocates and consumers of mental health services have long been concerned with the paucity of insurance coverage for mental health services and the discrimination in insurance against those with mental illnesses. We believe it is crucial that these problems be addressed in any discussion of public insurance programs and strongly urge the inclusion of such coverage in the legislation presently before the Committee.

Mental health care is an important component of the health care system as a whole. In 1986, mental health care accounted for approximately one-fifth of all hospital beds. An estimated 84 million days of hospital care were provided for mental disorders compared to 31 million days for heart disease and 22 million days for cancer. However, access to treatment and insurance coverage for those with mental illnesses is very limited. Among the people with private insurance plans, the access problems for mental health services is far more difficult than for those seeking physical health care because of the restrictions and limitations in coverage.

Although 99% of individuals and their families had coverage for some inpatient mental health treatment, only 37% had the same coverage as for treatment of other illnesses. Over 60% had fewer days of coverage or a special annual or lifetime dollar maximum for mental illness treatment.

For outpatient benefits, limitations were even more stringent. While 97% of persons with private health insurance had some coverage, only 6 percent had coverage equivalent to that for other illnesses. In addition, severe dollar limits were imposed. Only 24% of the plans reimbursed at higher than 50% of allowable charges. Where annual dollar limits were imposed, they too were more stringent than those for physical health treatment.

Finally, many private plans have "pre-existing condition" limitations or exclude "conditions not amenable to short-term

therapy" both of which impact more heavily upon those suffering mental illness.

The publically financed insurance programs, Medicare and Medicaid, maintain many of these same inequities. Medicare spends less than 3% on mental health and Medicaid excludes services from those between the ages of 22 and 64. Medicare contains special limitations including a life-time limit of 190 days of care in a psychiatric hospital and a 50% co-payment for public or private outpatient psychotherapy services as opposed to a 20% co-payment typical for almost all other outpatient treatments for physical illnesses. The complexities of the Medicaid program make generalizations difficult. We can say that overall the program includes less than 45% of all persons below poverty and that its full potential for services to mentally ill people has nowhere been achieved.

Mental illness knows no class, sex, race or age limitations. Recent data from the NIMH provides a picture of the breadth and impact of mental illness in the United States, particularly among the working age population. People aged 25 to 44 - in their prime working years - account for the largest percentage of admissions to inpatient psychiatric services. This represents a significant loss of productivity as well as an unacceptably high impact upon health and quality of life.

Any proposal for health insurance coverage must include mental health coverage which is appropriate. Improved treatment techniques have greatly reduced the use of inpatient treatment and also reduced the length of stay in hospitals. Today the overwhelming majority of persons with mental illness are treated out of hospitals. However, the design of insurance products and their projected costs are still predicated on the assumption of inpatient care and long-term therapy. This has resulted in disincentives by insurers and by employers to make mental health coverage available.

The Mental Health Association in Michigan strongly urges the Subcommittee to include adequate and appropriate coverage for mental illnesses. The coverage should be designed to include the following:

>reimbursement for state-of-the-art treatment

>tradeoff provisions between allowable days of hospitalization and outpatient visits, as long as the plan contains some of both benefits

>tradeoff provisions between inpatient care and partial hospitalization or day treatment

>prohibition against exclusions for pre-existing conditions.

>allowance for a wide range of providers.

>the requirement that basic mental health benefits be provided.

>coverage of psychotropic drugs

>incentives for enrollment of those presently receiving benefits via Medicaid and Supplemental Security Insurance.

Just as we would not permit 1/5 of the citizenry to be denied the rights and priveleges of the rest, we must also assure that the one in five Americans who - at some time during their lives - will be in need of mental health services will have those benefits available. The Mental Health Association in Michigan is ready to assist the Subcommittee in any way to reach that goal.

Finance Committee on Health for Families and the Uninsured.

From: Mary Lou Mitchell, R.N.

Re: Health Care Reform Legislation.

Date: Sept. 6, 1991.

I am here to express my views on cost containment, health care rationing and universal access to health care. I feel it is important that the focus of health care changes are on wellness instead of illness. My work experience has made me aware of some of the issues that are fundamentally wrong with health care today. I am now working in Utilization Review and Discharge Planning in a local hospital. Since 1974 I have been a Critical Care Nurse. These are issues that I, and many other health care providers, feel strongly about. I would like to share them with the committee.

Because of advanced technology and improved pharmacology health care is able to do more with less, more so than ever before. By this I mean that chronically ill and dying patients lives are prolonged at an estimated $50 BILLION a year; the bulk of our health care dollars are being spent on the last few weeks of life. (The Oregon Plan, Legislative Session Summary, June, 1989.) Many of these elderly patients have a mental impairment due to old age or illness and are unable to voice their desires, therefore are denied a dignified death. Frequently physicians must practice defensive medicine and deliver more care than they feel is appropriate, either because of mandates by Michigan Peer Review Organization or fear of litigation. The government and our hospitals foot the bill for these patients to live several more weeks or months. All too frequently the patient lives through the acute care phase, is discharged in a stable condition, only to die a short time later in another facility or at home, This cost to the tax-

payers is phenominal. It is a waste of our health care resources and dollars.

It is also estimated that 50% of aging is genetic and 50% due to our lifestyle. There are volumes of medical evidence that exercise benefits lifestyle and productivity. It has been stated that 67% of disease can be avoided with lifestyle changes; i.e. diet, exercise, smoking cessation, limited alcohol intake and an upbeat attitude. Bearing that in mind it seems logical that our health care dollars should be spent where it is most useful. The focus on health care and cost containment should be on prevention; instead of prolonging death we should be focusing on wellness! Our taxes would be more wisely spent on keeping our young and working people healthy. These are the people who will keep our state strong and productive. These are medically indigent people, families who are working and still can't afford insurance. This is the workforce of today and tomorrow. We need to prioritize health services based on the beneficial outcome of procedures or services on our population. Preventive health care, education and screening is where we should be spending our dollars. I am not an advocate of withholding care from the elderly, but instead, using common sense in caregiving and rationing more fairly.

In closing, I want to stress that it is important for our political leaders and health care providers to educate and send a message to our society that our health is our responsibility. This attitude, with your strong leadership, can be instilled in the people of Michigan. Too many people feel it's someone elses job. We can stay healthy longer with lifestyle changes, education, and prevention. Statistics have shown that for every dollar spent three can be saved. I would like to see basic care, screening and prevention available to all Michigan residents.

Thank you for listening to my views. If there is any way I can be of assistance please contact me.

Michigan League for Human Services

300 N. Washington Sq., Suite 401 • Lansing, MI 48933 • (517) 487-5436

STATEMENT FOR
SEPTEMBER 6, 1991
FOR
U.S. SENATE FINANCE SUBCOMMITTEE IN
HEALTH FOR FAMILIES AND THE UNINSURED

The Michigan League for Human Services is a statewide citizens organization which has been actively involved in the improvement of a broad range of human services for over 78 years through its planning, research, education and advocacy activities. As early as 1971 the organizations's statewide board called for "a comprehensive national health insurance plan. . . implemented in policy and in fact without delay so that adequate professional health care comes within the means of all citizens without regard to present life station, employment status, income or present family structure."

For the past decade, the organization has intensified its work on health care concerns. Since 1986 League staff have been extremely involved in access issues for both the underinsured and uninsured citizens of Michigan. An area of specific involvement has been access to health care insurance for the employed uninsured. The Health Care Access Project (HCAP), a demonstration project that the League developed in collaboration with the Michigan Department of Social Services, brought small employers and employees in Genesee and Marquette counties a subsidy if they would share the cost and initiate employment-based health insurance. Some of the data gathered thus far lends itself to this committee's deliberations over the merits of S. 1227. The following observations are contributed.

The first is regarding the "play or pay" design of the S. 1227 proposal. In the HCAP pilot, most of the small businesses contacted did not feel they were financially capable, even when their contribution was capped at one-third of the premium and a one-third subsidy was available, of providing coverage for their employees. Two years into the pilot, only 23.5 percent of the 976 employers who were determined to be eligible for participation in the pilot chose to be in the program. Approximately 76 percent of them did not (747 out of 976), citing cost as the primary reason. This would suggest that a "pay or play" system would have to include an effective mechanism for distinguishing those employers who actually cannot make a contribution to health care coverage for their employees. In a review of preliminary data for the followup evaluation of HCAP in Genesee County, 28 percent of the participating employers contacted dropped coverage after the subsidy ended in March of 1991 and another 20 percent indicated an uncertainty about being able to continue coverage. The approach suggested by S. 1227 may resolve some of these problems, and the League would urge the committee to continue to evaluate the benefits of such a solution.

The employees' share of premium payment is also addressed in S. 1227. The experience with HCAP in this regard is quite revealing. Very few of the employees in businesses that participated in the pilot chose to "go bare"--only 2 percent in Genesee County and 7 percent in Marquette. This is a significant finding considering the fact that only one in five had wages above $15,400. On average, employees paid out $47 per month in Genesee and $19.50 in Marquette, a relatively large investment of limited discretionary funds. What remains to be determined is whether or not individuals can sustain such a sizeable contribution over time, given the other pressures on their limited financial resources.

Managed care systems are discussed in S. 1227, and the League supports the concept. In HCAP, a large majority of participants in Genesee County chose to enroll in the HMO option; these participants generated costs that were 37 percent lower than enrollees in the "fee for service" coverage in the first year and 17 percent lower in the second. It would thus appear that the HMO's emphasis on case management in this instance had a significant impact on cost. However, quality of care must also be given primary consideration, particularly with regard to low-income individuals because it is in this area that problems have occurred--persons with resources have traditionally "voted with their best feet" when they perceived that their care was lacking in quality. Low income persons locked into a poor quality case management system, often do not have the resources to go outside of the system for alternative or supplemented care. Equal access and quality, regardless of method of payment, is essential to truly "universal" coverage.

Finally, the League would commend the committee and Senator Riegle for a significant effort to address the problems of cost, quality and access within the current system, and to make affordable health care of reasonable quality available to all Americans in the proposed modified system. As referenced above, the League has longstanding policy in support of universal health care coverage. In 1988, the organization's board reiterated its support for a national health care approach which "(1) recognizes that medical care is a basic right; (2) rejects the current patchwork approach to health care coverage; (3) provides all Americans regardless of age with the health care they need with an emphasis on primary and prevention services; and (4) is financed through tax policy which reflects the interdependence of all Americans, considers all tax sources in the economy, and accommodates the relative ability of different constituencies to pay."

It is within the context and spirit of this organizational position that support for current national efforts to resolve the health care crisis are made today.

2/HCAPgc.mar/ll
8/6/91

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Teresa Munz, Chapter Services Coordinator

Address: 409 N. Foster
Lansing MI 48912

Representing: Nat'l M.S. Society, Michigan Chapter

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I invite you to attach a prepared statement or to submit your written testimony:

*It was disappointing to see no people of color or people with visible disabilities as witnesses or on the panels *

People with Multiple Sclerosis need:

① access to physician of choice ② elimination of pre-existing condition clauses ③ more liberal policies about part-time employment without losing ~~ass~~ benefits ④ durable medical equipment ⑤ long-term care ⑥ personal assistance ⑦ medical leaves ⑧ hospitalization ⑨ prescriptions ⑩ counseling services ⑪ access to experimental treatments

DONALD W. RIEGLE, JR.
MICHIGAN

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HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Jean C. Myers

Address: 2757 Eastway Dr
Okemos, MI 48864-2405

Representing: self

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I invite you to attach a prepared statement or to submit your written testimony:

Now when health care can make possible improvements in peoples lives, it is reasonable to expect people to want these benefits. Legislation offers many positive approaches to making quality care accessible to the population at affordable cost. The dependence on continuing to tie health care to employment obstructs reaching these goals. The insurance aspect is a major stumbling. A linkage with pools with the characteristics of the Medicare Program could resolve much of the cost shifting and answer the concerns such as medical malpractice liability, insurance mandates, because the present costs hidden in tax credits, scope requirements by benefit packages, etc. because coverage covered by a national health care that would be assured, that cost is available without getting lost in the present maze of eligibility hurdles. Emphasis on health care as opposed to just acute care experience many of the cost & access problems. The phase in of children & pregnant women is a step toward. Moving from preventive care but we need the legislation to consider the preventive benefits associated with chronic and long term care. Move away from the private sector reliance on insurance plans beyond the "legal pay" schemes toward the universal coverage, single payer plans.

New Age Patriot Newsletter
P.O. Box 419
Dearborn Heights, Michigan 48127
(313)563-3192

Address by Bruce W. Cain (Editor of New Age Patriot) before Senator Riegle's Committee on Health Care in America - Friday September 5, 1992 at the Kellogg Center in East Lansing Michigan.

"A ounce of prevention is worth a pound of cure"

I would like to thank the Honorable Senator Donald Riegle for both inviting me here to day and for furnishing me with a copy of "**Trauma Care: Lifesaving System Threatened by Unreimbursed Costs and Other Factors.**"

In this GAO report, on Trauma Care, is the following passage:

> "Nationally, blunt trauma -- caused by motor vehicle crashes, falls, or other blunt forces -- represents about 80% of trauma injuries. However, penetrating trauma, primarily caused by guns and knives, represents a growing share of urban trauma injuries. This is particularly true in inner-city areas where crime- and drug-related violence has been rising. Many hospital officials point to this shift in patient mix as a force that contributes to their deteriorating financial position and decision to end participation in organized trauma system."

What percent of the total trauma charges are due to this 20% (and growing) slice of drug related trauma? As it states in the report:

> "In Chicago, a trauma center reported that 52% of its trauma patients had penetrating injuries; 79% of these were uninsured and 13% were covered by government-assisted programs."

It is unfortunate that after describing the demise of our Trauma Centers, in great detail, this report ends with NO recommendations:

> "GAO is making no recommendations."

Most politicians continue to take the view that most of this drug related violence is a result of ingesting drugs, which precipitate violent behavior, which leads to these "penetrating" trauma injuries. This is very convenient because, by subscribing to this specious theory, they can ignore many of the symptoms that truly underlie this violence: poverty, joblessness, angst and despair. The truth of the matter is that most of this violence results from the Drug War itself. By criminalizing drugs like cocaine, you make their sale the last vestige of well paying labor opportunity for Urban America.

It is well beyond the scope of my address to explain the various dynamics underlying the current drug violence. But growing numbers of professionals are beginning to understand this dynamic and are calling for an end to the Criminal Justice Approach to the Drug War. These people - Educators, Government Officials, Criminal Justice Experts, Journalists, Physicians and Clergy - are calling for an end to the Drug War. I highly recommend that you read my compilation of these people which is contained in a **New Age Patriot** publication entitled **"Americans Supporting Drug Legalization." [This can be purchased by sending $1.50 to New Age Patriot].** It is time that we take the profit - and thus the violence - out of the drug market. Only then can we effectively treat drug abuse as the Public Health problem that it is.

In order to change the focus of drug abuse - from a criminal justice problem to a public health problem -

hundreds of organizations are planning **"International Drug Policy Day" on April 4th 1992.** We will be calling for immediate legalization of marijuana through a model similar (and no more restrictive) than the current alcohol model. We are also using the week preceding this event to educate America as to the real issues in the drug war. Any one interested in participating should get in touch with me through the **New Age Patriot Newsletter.**

AIDS is another factor cutting into the viability of our Public Health infrastructure in this country. George Bush made another of his uneducated assessments, of the AIDS epidemic, outside his million dollar home in Kennebunkport last Sunday:

> "Well, I'm not in favor of federally funding needle (exchange) programs. I am in favor of the most efficient and effective research possible. I'm in favor of behavioral change. Here's a disease where you can control its spread by you own personal behavior. So if the message is compassion, I got it loud and clear."

How does a fetus protect itself from its HIV infected mother George? How do blood recipients protect themselves from non-autologous blood donation? According the Centers for Disease Control over 50% of the 14,816 women with AIDS (U.S. Women only) contracted the disease by sharing dirty needles (USA Today 11/27/90). I researched an article on needle exchange programs 2 years ago and even then it was evident that needle exchange programs markedly reduce the spread of AIDS as well as offering an opportunity for treatment. It bothers me that Bush calls himself the education president but refuses to acknowledge the facts and the opinions of those most knowledgeable on the subject of needle exchange programs. Just 2 weeks ago the Yale Medical School became the most recent advocate of needle exchange programs. How many more babies will have to die of AIDS before George is convinced that needle exchange programs are an idea whose time has come?

I believe it was Benjamin Franklin who once said that "a ounce of prevention is worth a pound of cure." Drug legalization prevents "penetrating trauma injuries" by robbing illegal drugs of their value. When was the last time you heard of someone killing for a beer? Needle Exchange programs prevent the spread of the AIDS virus by stopping the sharing of dirty needles. Both propositions deserve sincere consideration not only because of their financial benefits, but also because they represent an alternative which is far more compassionate (and effective) than present policy.

I urge people to educate themselves about alternatives to the drug war by reading my policy paper: **RDLER (Regulated Drug Legalization, Education and Rehabilitation): A Framework for Legalizing Drugs.** I encourage people to educate themselves to the fact that needle exchange programs work and in no way promote the use of drugs. And I urge all of you to become active in **International Drug Policy Day on April 4th, 1992.** But most of all I urge all of us here today to find compassionate solutions to drug abuse and other problems: solutions that do not further denigrate the suffering.

Bruce W. Cain
Editor of New Age Patriot
Bus. Number (313)563-3192

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: Mark Notman

Address: Dept. of Family Medicine W. Fee Hall E. Lansing

Representing: Cor 714 N. Magnolia Lansing, MI 48912

****

I invite you to attach a prepared statement or to submit your written testimony:

After hearing the testimony presented:
The proposed legislation is a notable attempt to do something long overdue. No one, however, mentioned (or one aspect of it) reform of physician payment. The problem, as I see it, is not that Medicaid reimburses 41% of physician costs — as one ~~comm~~ commentator mentioned — it's that physicians charge too much to begin with and too many are unwilling to treat patients from other socioeconomic strata dissimilar from their own privileged position. This problem needs to be addressed along with the other aspects which the legislature attempts to deal with.

DONALD W. RIEGLE, JR.
MICHIGAN

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HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: Joanne M. Pohl

Address: Life Sciences A230
MSU
E. Lansing, Mi. 48823

Representing: Michigan State University - College of Nursing

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I invite you to attach a prepared statement or to submit your written testimony:

The Plan is a step in the right direction - However there is no long term Care plan - with changing demographics, that must be addressed.

I am not clear how this plan will address our present dual system of care with medicaid (& no insurance) clients & those with private insurance. Will providers continue to reject those with the "public-plan".

Plan needs to include nurse providers (nurse practitioners) to Contribute to primary care providers, often in high need areas!

I also have concerns linking employment with health care coverage. The Canadian plan does not do this, nor does the Physicians for a National Health Plan Proposal. These plans in addition more adequately address the high cost of private insurance; that is a major criticism of our existing plan.

DONALD W. RIEGLE, JR.
MICHIGAN

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WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Norma Prouty

Address: 4690 Kingswood Drive
Okemos, Michigan 48864

Representing: AMI of Greater Lansing, Okemos Township Dr

****

I invite you to attach a prepared statement or to submit your written testimony:

The Alliance for the Mentally Ill is interested in appropriate insurance for the mentally ill persons in need of quality care; hospital, or a suitable facility in which to live for an indefinite time.

Agnew Reid

$700 per car re: health care costs U.S.
323 in Canada per car

Sen. Reigle didn't mention ~~sitting~~ setting a control on soaring hospital costs.
One could reduce paperwork - bookkeeping accounting + insurance by simply having ~~Socialized~~ Socialized medicine. ~~the~~ Health
the public wouldn't need insurance.
As long as you have a 2nd party ~~payor~~ payor you will always have soaring hospital costs.
One wouldn't need to fear being turned down for health insurance ~~if~~ if you had socialized medicine. You wouldn't need Health insurance.
The money that you would use for health insurance premiums could be paid to the govt to control Socialized medicine.
You wouldn't need to travel around the Country having panels present their testimony.
You could eliminate many costs.
Insurance premiums + rising hospital + medical costs go hand in hand. As I mentioned before as long as there is a 2nd party ~~payor~~ payor (insurance Companies) you'll always have increases + increases, because the Docs tend to charge more when you have insurance.

Semi-Socialized medicine or Socialized medicine would eliminate many obsticales. The public should not have to loose their life savings to cover an enormous hospital bill + medical bill. If one looses their job - they loose their insurance. This should not be. Are our laws encircled around the rich?
The Doctors are getting rich, the hospitals are getting rich + the lawyers are getting rich!
Take heed of the testimony of the panel - Mr. Bond presented many good points
My insurance premiums are increasing + increasing.
Our health system + our educational system should be controlled by the Govt.
If you want to be a leading world nation you need ~~smart~~, intelligent healthy people!
Now senators if you can find a way of controlling our growing birth rate you will eliminate our growing garbage, welfare housing problems + other problems that arise from our growing population! & could go on + on + on!
If a business "buys" a Congressional seat, (elections) then who is out there to help the public?!
There is too much greed out there -- were going down the proverbial tube!
Where is the money coming from for the new American system? The Govt (the public.)
We're being used! Middle america is being used to pay for everyone else!
I would like to hear from one of the Senators or special panel in Washington.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
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WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: ERNEST SANCHEZ

Address: 1040 S WINTER
ADRIAN, MI 49221

Representing: Department of Social Services
Lenawee County

****

I invite you to attach a prepared statement or to submit your written testimony:

that the mechanics enacting any such plan not be so darn complicated that those of us between the providers & those needing the services get lost in the policy interpretations - simplicity seems best.

TRACEY L. SASS
5614 ASHLEY DRIVE
LANSING, MI 48911
(517) 887-8093

September 6, 1991

Senator Donald W. Reigle, Jr.
United States Senate
Washington, D.C. 20510-2201

Dear Senator Reigle:

Thank you for the invitation to attend the Senate Finance Subcommittee on Health for Families and Uninsured on September 6, 1991 in East Lansing, Michigan. Although I am unable to attend this first meeting, I have ordered a copy of the summary of Senate Bill 1227, the "Health America" bill you described in your August 2, 1991 letter. It is fortunate that we have leaders such as yourself who recognize the disastrous state America's health care systems are approaching. Good luck in your work on this project. I am sure it is worth all the efforts you will be making.

I will be reviewing this bill with an eye towards, of course, where such legislation would fit into the needs of my family and others whom I know that do not have insurance and truly need it. This letter is intended as testimony, but I wish to provide further, more detailed testimony for the bill in general and am unaware of of what the final date and place of acceptance of such testimony for the bill is. Please let me know at your soonest convonience.

But also, my review will take on another consideration. I am one of many Americans who choose methods of health care that are less risky, more natural procedures. By this, I mean that instead of birthing our last son in a hospital setting[1], we hired a midwife and birthed a healthy boy at home. And, I mean instead of antibiotics (which usually kill as many normal bodily bacteria that are necessary for the human body to function as they kill infectious bacteria, and sometimes not even then) as a remedy to cold bacteria, I use homeopathic remedies, the "like treats like" alternative to many illnesses. I mean, when the friend to whom I offer labor support visits her physician, we request the use of non-electrical or non-pulsating devices to listen to fetal heart tone (usually more accurate and less risky anyway). I mean, instead of seeking spinal manipulation by an M.D. or D.O. for back problems (who generally bill $60.00 under "physical therapy"), I see a D.C. (Doctor of Chiropractic), whom usually charges only $25.00 and bills it properly to my insurance.

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[1] Where drugs, monitors, and other interventions are practically forced upon the laboring mother as "standard operating procedure"--even when not proven necessary. These procedures are wonderful--if needed.

By making use of these effective alternatives, I save hundreds, indeed thousands, of health care dollars--for my insurance, my employer, and my wallet!

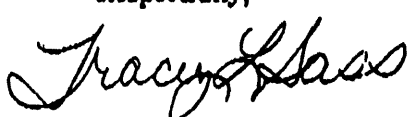
However, the biggest problem has been that a physician may prescribe homeopathics, but they are not paid for under prescription coverage. This has the effect that, although homeopathics are less expensive per remedy, some people can't afford to go outside of their insurance coverage and are forced to seek the more expensive, less desirable remedy. Midwives are lucky if insurances cover their labor and delivery assistance services at all, and many couples take a routine M.D. or D.O. delivery with nurse-assisted labor care (which is at least twice as expensive as a midwife) because that is all their insurance will allow and after paying the insurance premiums they cannot afford uncovered alternative care. Patients with spinal and related problems are forced to seek more expensive, and almost always less experienced and less educated for the purpose, services of an M.D. or a D.O., because most insurances have a "limit" on the number of visits to a D.C. that are covered per problem.

What is this anyway? Is America being forced by these insurance dictates to seek more expensive treatment--driving the health care and insurance costs up for everyone? What does this to do the general economy in the long run? I don't think I have to spell it out further.

I am confident that you and your associates on the Senate Finance Subcommittee on Health for Families will take this information into sincere consideration when you are preparing the language of the administrative rules for the health care cost reduction program. By "widen(ing) access to health care" alternatives, you widen choices that can save America millions.

Please take the time to think about these issues as a whole. America's choices in health care could be yours--or that of a program rule--instead of the individuals'.

Respectfully,



Tracey L. Sass

CC: N.E.W. Birth Organization
Michigan Chiropractic Society
American Chiropractic Society
Senator Carl Levin
Representative Robert Carr
Representative Howard Wolpe
Michigan Senator John Pridnia
Michigan Senator John Schwarz
Michigan Senator Mat Dunaskiss
Michigan Senator John Kelly
Michigan Senator Donald Koivisto

Dear Senator Riegle,

I am excited to see that you are taking action on our health care crisis. The problem of health care for the uninsured should be a major concern for every person holding a public office.

I do not have health insurance. I am a 33 year old, divorced mother of two. I am in the last year of my B.S. in nursing at M.S.U. I had been working part time and with child support payments, making ends meet. One of the ways I made ends meet was to skip my yearly pelvic exam and pap smear. I missed 2 yearly exams and scraped up the money for the 3rd year. The results of that exam indicated cervical pre-cancer. I had a high grade lesion and required several diagnostic procedures and two surgeries over the next year. I am now recovering from a complete hysterectomy. I was lucky, I did not have invasive cancer. If I had gone for the 2 exams I missed before finally going for the third, I might have caught the problem much earlier and required a lot less treatment, and probably could have avoided a hysterectomy.

I went to the department of social services and was lucky enough to qualify for medicaid. But I could only get it by giving up my child support and going on A.D.C. This was a major humiliation for me, I prefer to scrape by on my own, but I didn't seem to have a choice. Even if I had had the money, no insurance carrier would have taken me

knowing the extent of the treatment I required. In terms of tax dollars it would have been a lot cheaper to pay for my routine exams with something like AmeriCare and avoid the long term expense of letting the problem go until it required major surgery.

Part time employees and under insured full time workers really get a bad deal when it comes to health insurance and medical treatment. Our tax dollars support federally funded hospitals that train medical personnel. Medical research funding and tuition money for medical students comes from tax dollars. We pay the taxes and are denied access to the medical care when we need it. Instead we are turned away from hospitals, pay huge bills if we manage to get treatment or if we are lucky, get on welfare and medicaid.

I am looking forward to attending the Official Hearing on Sept. 6 at the Kellogg Center. I hope your bill is successful. Thank You for your concern about the uninsured and under insured.

Sincerely,

Terry Scharf
804 Meadowview
Lansing, MI
48917

517-323-6304

Copy of Bill - please

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Send Out 9-16 PJ

Sign In
Name: Loyd Lewick

Address: 1265 Scott Dr.
East Lansing, MI 48823

Representing: self

****

I invite you to attach a prepared statement or to submit your written testimony:

Re: provider reimbursement
Would like to see more reimbursement through this plan to nurse practitioners and clinical nurse specialists - not only for young individuals but towards the care of an increasing elderly population.
Medicare fails to address services that may be provided by clinical nurse specialists or nurse practitioners practicing outside of long term care facilities

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
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United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: James J. Simmon

Address: 1269 Roslyn
Grosse Pointe Woods MI 48236

Representing: American Community Mutual Ins. Co.

****

I invite you to attach a prepared statement or to submit your written testimony:

In order to offer an affordable health care product, private insurers desparately need controls over increasing provider costs. Given these controls and the ability to sell an "Americare" clone, the natural efficiency of private insurers should be able to outperform either service or premium-wise, a federal program. All to the public benefit.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
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United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Betty W. Smith

Address: 4903 Sugarbush
Holt, Mich., 48842

Representing: Alliance for the Mentally Ill of Mich.

****

I invite you to attach a prepared statement or to submit your written testimony:

It is imperative that the severely mentally ill be able to obtain hospitalization when it is needed, - for whatever period of time as is advisable. It is often difficult to obtain hospitalization for any length of time.

If new legislation is passed I hope the severely mentally ill will be covered by the insurance they need. I hope they do not lose any insurance coverage they have now including private insurance. Medicare lifetime hospitalization Coverage of 190 lifetime days should be greatly extended. *

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
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BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Deborah Spicer, Public Affairs Co-ordinator

Address: 425 Cherry Street, S.E.
Grand Rapids, Michigan 49503

Representing: Planned Parenthood Centers of West Michigan

****

I invite you to attach a prepared statement or to submit your written testimony:

My concern about this bill is the "state's rights" provision to determine optional services. Does this mean that some states will be able to continue to exclude certain legal medical services available in other states? Would it cover all legal benefits or have an elective termination rider? What parameters outline "basic health care"? Where will a foundation of family planning as a basic health service be placed? Who will decide?

We must be careful not to create a monolithic government where a state would impose its bureaucracies on health care benefits to low income women.

Thank you for your commitment and endurance on this important issue. Sincerely, Deb Spicer

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Glenna Gruta

Address: 530 W. Beech St.
Charlotte, MI 48813

Representing: Eaton County Medical Care Facility

****

I invite you to attach a prepared statement or to submit your written testimony:

ECMCF is a long term care facility.
Health America is a start of something that has been needed for a long time.
Our company cannot afford to give our part time employees health insurance & if it weren't for medicaid 50% of our residents would not be alive.
But medicaid cannot do it all.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS: Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510-2201

HEALTH AMERICA; AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Dora A. (Sally) Swartz

Address: 4568 Comanche
Okemos

Representing: myself -

****

I invite you to attach a prepared statement or to submit your written testimony:

I commend you in sponsoring this very needed program and to opening it up to a wider range of people with special expertise, needs & problems. I trust their & other info is used to fine tune this bill. Managed care & cost containment promise real benefits.

May I wish you great success in getting this through congress & with administration support with as little political bickering as possible.

STATEMENT

ON THE DEVELOPMENT OF A PROGRAM TO FINANCE AND ASSURE ACCESS TO HEALTH CARE

United Community Services of Metropolitan Detroit
September 6, 1991

My name is Jacqueline Flowers Martin. I am the Planning Associate, Health Services Division of United Community Services of Metropolitan Detroit. United Community Services is the primary citizen-based social planning and problem solving organization in Southeastern Michigan. For over seventy five years, UCS has dealt with health and human services issues, as they affect metropolitan Detroit. Health policy and how to assure access to basic, comprehensive, affordable, culturally relevant and acceptable health services continues to be one of the major concerns of our over 900 active citizen volunteers.

On behalf of UCS, I appreciate this opportunity to present our observations on the development of a program to finance and assure access to health care for all Americans. I would like to share our basic philosophy and discuss four attributes we think must form the foundation for an acceptable plan to finance and pay for health care for all Americans and ten principles that must be addressed in such a plan. I will also share with you our assessment of Health America's consistency with out attributes and principals.

It has been a long held notion in America that access to health care was an inalienable right, somewhere in there with life, liberty and the pursuit of happiness. In fact for most of the history of this country, that was the case. The most serious barrier to health care was the lack of availability of the appropriate providers and facilities. In the 1940s the Hill-Burton Legislation encouraged the building of health care facilities to alleviate shortages in rural as well as urban areas. In the 1960s we recognized that inability to pay could be a serious barrier to

medical care. The Medicare and Medicaid amendments to the social security legislation were passed to insure access for those thought to be most vulnerable, the aged and poor. Now in the 1990s, we again see access to health care threatened. This time it is a crisis of cost. Incredible advances in technology have given us a medical care delivery system that requires more of our resources than the American public is apparently willing to pay. consequently, we are faced with a new reality--that access to health care is only a right for some.

The bottom line is that we can't or choose not to provide all possible health care for all Americans. Currently, our system seems to provide all for some and very little or none for others. A sense of fairness and justice would tell us that we should provide some (basic comprehensive health care) for all Americans.

Basic comprehensive health care should probably be defined as including health promotion and risk reduction, preventive health services, basic diagnostic and medical care in a hospital or physician's office, but excluding experimental procedures, custodial care and that care which artificially prolongs death rather than extends life.

The health status of people living in the United States (one of the richest and most technologically advanced nations on earth) lags behind that of most nations in the industrialized world. This deficit in health status persists, even though our health expenditures as a percent of gross national product (GNP) and per capita health expenditure are the highest in the world. Both are consistently rising. Health status is not. More distressing is the disparity in the level of health among various segments of the nation.

This situation is either caused or severely exacerbated by an inadequate, fragmented, haphazard system of financing and paying

for health care. While all other industrialized nations (except South Africa) have a structured, comprehensive method of financing health care for all of its citizens, the United States relies on a patchwork of federal entitlement programs for the poor and elderly, and employment-based private insurance for the majority of other Americans. More than 37 million or 15.7 percent of all Americans under the age of 65 percent have no public or private coverage. Most of the uninsured are children. Two-thirds of the uninsured are either employed or the dependents of employed persons. This employment is full time for 45 percent of the uninsured. In Michigan there are more than one million people or 11 percent of the population without any type of health coverage. The system is not efficient, even for those persons with coverage. The system of purchasing and paying for health care promotes and sustains an environment with perverse incentives for high cost procedures, regardless of quality or contributions to health status or outcome and devoid of accountability or incentives for quality and cost-effectiveness.

The nation's expenditures on health as a percent GNP and on a per capita basis continue to rise. According to the most recent statistics, the U.S. spent $676 billion on health care or more than 12 percent of its GNP in 1990. This figure has risen consistently at an average rate greater than the growth in GNP for the past 20 years. Indicators of health status are not keeping pace. The U.S. life expectancy is 75.3 years, far from the highest among the industrialized nations. Infant mortality is 9.7/1000 live births, 14th among industrialized nations. Minorities and the disadvantaged have significantly shorter life expectancies, higher infant mortality and a greater prevalence of chronic disease.

The American system (or non-system) of financing and payment mechanisms contributes greatly to the diminished cost-effectiveness of the American health care delivery system. The current system of health care financing and payment mechanisms:

- excludes more than 37 million Americans;
- places an undue burden on those employers who offer comprehensive health insurance to their employees;
- places in financial jeopardy those institutions/providers treating uninsured, under-insured persons or those covered by programs (payers) paying less than 100 percent of costs;
- allows underpayment by major programs/payers and the resultant cost-shifting;
- encourages the choice of method of treatment and treatment setting based on perceived reimbursement, rather than clinical appropriateness or cost-effectiveness;
- provides payment incentives for the provision of procedures regardless of their clinical appropriateness or cost-effectiveness, and for the provision of procedures in the most costly fashion possible;
- provides dis-incentives for technology to become less costly;
- provides payment dis-incentives for cognitive services, including health education and preventive services, which ultimately lower the cost of health care;
- does not encourage sufficient personal accountability for health status and costs;
- makes almost impossible significant measures of the clinical appropriateness and cost-effectiveness of services provided;
- contains/employs a variety of complex complicated formulae which make true cost comparisons among institutions difficult, if not impossible;
- veils the cost of debt, capital, medical education and research, and professional liability insurance and defensive medicine;
- confuses bad debts with charity (uncompensated) care;

- causes unnecessarily high administrative costs; and
- does not promote nor encourage the matching of capacity with service need and encourages a mal-distribution of resources.

Most attempts to correct the payment and financing system have emphasized simple cost cutting without restructuring the environment (economic incentives). Attempts to reorganize the delivery system have fallen victim to the same, often counter productive financial incentives. All of this has occurred without benefit of national policy or planning. The result has been a piecemeal, pluralistic, duplicative, uncoordinated method of financing and paying for health care services that does not promote nor provide universal coverage, entitlement or access; incentives for the appropriate allocation and use of resources (cost-effectiveness) economic fairness and social justice, as related to the financing of and payment for health care services and assurances of clinical appropriateness or quality.

UCS recommends the development of a plan to finance and provide appropriate access to health care to all Michiganians/Americans. **The basic principles of an acceptable plan to finance and pay for health care must include the promotion of provision of:**

1) **universal coverage, entitlement or access;**
2) **incentives for the appropriate allocation and use of resources (cost-effectiveness);**
3) **economic fairness and social justice, as related to the financing of and payment for health care services and;**
4) **assurances of clinical appropriateness or quality.**

The current health care financing and payment system lacks or is deficient in all four of these areas. The very basic flaws in the current system make it an unsuitable foundation for a new plan.

New programs for universal health coverage must be considered. In order to be acceptable proposals for reform must be built on the previously mentioned principles.

We realize that developing a plan for universal access to basic health care is not only an enormous task but a multi-faceted one, encompassing a myriad of quality, delivery, reimbursement, eligibility and cost concerns. Three areas that must be interwoven into an effective health care system are health promotion and risk reduction, delivery effectiveness, and benefit and finance alternatives. The area most appropriate for legislative intervention is benefit and finance alternatives.

The remainder of this testimony will deal primarily with benefit and finance alternatives. It focuses on the following questions: what should be paid for, for whom, who should pay, how much and how should the resources be raised and allocated. Other aspects of a health care plan will be addressed only in so far as they dramatically impact benefit and financing alternatives.

Ten basic components contained in most proposals for a national health care system have been extracted from statements from labor, business and advocacy groups. UCS feels that the following components should form the framework for any health care financing reform program.

Universal Coverage...All residents must be covered by the system, regardless of income, age, gender, race, health status or disability, employment, geographic location or any other factor that previously impeded access.

Comprehensive Basic Benefits...The plan should cover a broad spectrum of health care services ranging from preventative to curative to long-term care. In order to be covered, services

must be determined to be medically necessary and economically feasible and appropriate.

Out-of-Pocket Charges...Charges should not present a barrier to the appropriate use of health care services. Modest charges could be used for program support and to encourage appropriate utilization patterns.

Equitable and Progressive Financing...Financing of health care delivery system must be broadly-based, with federal and state governments, employers and consumers jointly responsible.

Cost Containment and Provider Payment...Strategies should include a single-payer (administrative agent) system for providers, eliminating uncompensated care and cost-shifting, addressing the liability (malpractice) issue and capital expenditure planning and budgeting.

Hospitals and institutions could be paid on a prospective basis. To eliminate medically unjustified increases in admissions, regional expenditure targets or volume performance standards could be developed and applied. Physician fees should be fixed and based on a resource based relative value scale. Other professional fees could be set in a similar manner. Payment reform should be applied to prescription drugs, diagnostic and other appropriate services.

The state could purchase malpractice insurance for all qualified licensed providers/physicians in the state or self-insure for malpractice.

Program Administration...A single payer (administrative agent) arrangement, administered by the state or a payer chosen by the state, is recommended because it offers the greatest

potential for cost containment. A program that allows private insurers as intermediaries could also be acceptable, if the primary payer has sufficient clout to control costs and reduce administrative overhead. Universal access is only affordable with effective policies in place to contain health care costs. An area of potential significant savings is health insurance administration.

Sylvester Berki of the University of Michigan estimates that a single payer plan, through increased efficiency, could reduce administrative costs in Michigan by as much as one half, from 19 percent to 10 percent. By reducing the excess costs of the current complex multi-layered system of programs, a single payer plan with universal coverage (including the 1,000,000 excluded persons), appropriately designed, would cost no more than is presently being expended for health care in Michigan. With the right safeguards in place, health expenditures would be expected to grow only two percent per year. Savings, relative to expected expenditures if the present trend lines continue in the next decade, could amount to $45 billion in 1987 dollars.

On a national level, a single payer plan is projected to produce net savings of $17 billion in the first year. This would cover the expected $12.2 billion cost of providing coverage to those presently uninsured and produce an actual savings of $4.8 billion overall, per year.

Health Planning... Procedures must be in place to manage and rationally plan for capital expenditures (including new construction and renovation of existing facilities) on the basis of local, regional and state needs. Medical research and the acquisition and distribution of new technology must also be planned and coordinated. A health planning process would establish training targets for physicians and other

medical personnel. A statewide teaching cost fund could be established based on the estimated cost of meeting training targets by specialty.

Hospital capital expenditures could be budgeted and paid for on a state wide basis. This "Capital Budgets Fund" could be financed through set-asides from a single-payer system. The planning process could determine capital expenditure targets and establish guidelines to meet medically appropriate community needs.

Quality Assurance... Mechanisms must be in place to assure the delivery of quality services in all health care settings and to strengthen the peer review, education and professional licensure procedures. The system should collect and disseminate information about provider performance, health care outcomes and the appropriateness and effectiveness of health care services. Utilization management mechanisms must be developed, improved and incorporated into the system.

Free Choice of Health Care Providers... The delivery system could be essentially unchanged. Facilities could still be governed by their respective boards and individual providers could continue to practice as they do now. Health Maintenance Organizations (HMOs) or Alternative Delivery Systems (ADSs) could qualify as providers.

Consumer Representation and Patient Rights... The agency that administers the program, as well as the health plans that deliver services, must provide a mechanism through which consumers can influence decisions on policy and administration. Patients must be treated in a timely manner and with compassion and decency. Patient grievance procedures

must be established. Consumers, representative of the community should be represented on all decision making and oversight committees.

The above ten components must form the foundation for an acceptable health care plan. Proposals that have surfaced for implementing a national(or regional) health care system present four options.

A. Single-payer(administrative agent) programs would administer payment for covered benefits through a state agency, but retain present delivery systems.

B. Multiple-payer programs would allow private insurers as intermediary payers while a single public agency in each state serves as the primary payer. Also, present delivery systems would be retained.

C. Dual-track programs mandate large employers to provide health benefits for their employees. Everyone else would be covered by a public program.

D. Population specific programs extend coverage to certain segments of the population, in an effort to patch together universal coverage through a variety of non-equal programs.

After carefully reviewing and evaluating options being considered, UCS encourages and supports the development of a plan to finance and provide appropriate access to health care for all Michiganians and Americans consistent with the above listed principles and components.

UCS maintains that in order for the plan to be optimally effective, equitable and efficient, it must be a single payer (administrative agent) plan. A multiple payer plan, appropriately designed, could be acceptable if appropriate cost-effectiveness could be demonstrated.

Population specific programs and Dual track programs, such as Health America were deemed fundamentally unacceptable.

Washington Business Group on Health

777 N. Capitol Street N.E. Suite 800 Washington, D.C. 20002 (202) 408-9320 TDD (202) 408-9333 FAX (202) 408-9332

June 4, 1991

The Honorable George J. Mitchell
The Honorable Edward M. Kennedy
The Honorable Howard M. Metzenbaum
The Honorable Donald W. Riegle, Jr.
The Honorable John D. Rockefeller, IV
United States Senate
Washington, D.C.

Dear Senators:

The Washington Business Group on Health (WBGH) is an organization of large employers that has long been involved in public sector efforts to improve health care delivery and financing. We commend you for your intensive work on health system reform. The leadership which you have exercised by introducing Health America: Affordable Health for All Americans will move the ongoing national debate about health care into a new and more productive phase.

WBGH's members share your goal of constructing a health care system that provides all Americans with access to appropriate medical care at an affordable cost. The reforms necessary to establish such a system must involve individuals, purchasers, providers and government.

We have reviewed a preliminary summary of Health America. Based on this preliminary summary, it appears that your proposal represents an important change from legislation previously considered in the Senate. Prior proposals focused on expanding access to insurance, without addressing the corrosive effects of out-of-control costs, unnecessary and inappropriate care, and the fragmentation of the health care delivery system. While we reserve judgment on the merits of the particular mechanisms included in your current proposal, on the whole it demonstrates your commitment to comprehensive reform encompassing access, cost management and improved delivery of services through organized systems of care. This commitment establishes the basis for WBGH to enter into a dialogue about your specific proposals.

WBGH supports many of the concepts included in your legislation, though we emphasize that our ultimate position will be determined by how these concepts are applied. In particular, we support the use of strong incentives to promote managed care in public and private plans. In WBGH's view, the transformation of service delivery into what we have termed "organized systems of care" is the linchpin of successful health system reform. Reforms that do not promote this transformation are simply not viable.

Other concepts contained in your legislation which we support include:

- use of strong incentives to promote managed care in public and private plans;
- medical malpractice liability reform;
- reduced cost-shifting from public sector to private sector payers;
- pre-emption of state mandated benefit laws;
- recognition of the need to address anti-managed care laws;
- small group insurance market reform;
- expanded use of practice guidelines and expanded outcomes research and technology assessment;
- standardized claims and billing forms; and
- certain functions to be performed by "state consortia," assuming that the consortia are purchaser-driven and used to promote organized systems of care.

WBGH supports your goal of restructuring and expanding publicly funded insurance for lower income persons. We believe a restructured program must include: (1) aggressive use of organized systems of care to deliver services on an efficient and effective basis, (2) broad-based financing and reimbursement policies that do not shift costs to private payers, (3) a mechanism for setting spending priorities that encompasses all publicly funded insurance programs for lower income persons, and (4) a commitment to meet the needs of vulnerable populations, particularly children with special needs. WBGH will review your proposal to create an "Americare" program and modify the Medicaid program in light of these principles.

The "play or pay" approach to expanding insurance coverage, voluntary expenditure targets, rate setting, and the availability of insurance coverage to some businesses on terms that could permit cost-shifting remain highly controversial in the business community. WBGH will carefully evaluate these proposals in the context of your overall health system reform plan.

WBGH is now conducting an in-depth analysis of your entire bill. We will submit our detailed comments and suggestions in short order.

Again, we appreciate your effort to provide a useful starting point for resolution of the health system reform debate.

Sincerely,

Mary Jane England M.D.

Mary Jane England, M.D.
President

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