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REFORM OF THE HEALTH CARE SYSTEM

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

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MONDAY, FEBRUARY 25, 1991

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

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: Senators Packwood and Danforth.

[The press release announcing the hearing follows:]

[Press Release No. H-3, Feb. 19, 1991]

HEALTH SUBCOMMITTEE TO HOLD HEARING ON REFORM OF THE HEALTH CARE SYSTEM; ACCESS TO HEALTH CARE AND COST CONTROLS TO BE THE FOCUS

WASHINGTON, DC—Senator Donald W. Riegle Jr. (D., Michigan), Chairman, announced Tuesday that the Subcommittee on Health for Families and the Uninsured will hold a hearing on the need for health care reform through expanded access and cost controls.

The hearing is scheduled for Monday, *February 25, 1991 at 10 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

"Our health care system—the most advanced and sophisticated in the world—has failed us in two important ways. Tens of millions of Americans are without health insurance and rising health care costs threaten the availability of health care for those who currently have coverage. A more efficient, better designed health care delivery system could provide care to all Americans," Riegle said.

"Diverse groups, representing all sectors of society, including business, labor, health care professionals, insurers, State and local governments, and other advocates, are all asking for significant health care system reform. This hearing will examine the need for health care system reform and specific solutions. All interested groups support some type of change. We will hear from many of these groups and coalitions," Riegle said.

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

Senator RIEGLE. The committee will come to order. Let me welcome all those in attendance this morning.

Today is a very important day with respect to the work we take up here together. We will be hearing from individuals representing many key sectors of our society about the need for a systematic reform of this country's health care system. The testimony that they will be providing us will give us just a few examples, but important ones of the growing outcry across the country, voices to solve the interrelated problems of limited access to health care or no health care for many Americans, and on the other hand an ever-rising level of costs for health care.

This is the first of many hearings that Senator Chafee and I plan to hold in the Finance Subcommittee. I want to say that Senator Chafee very much wanted to be here today, but a pressing matter required his being in Rhode Island. I am going to be including a full statement for the record today. But as I say, this will be the first of many hearings that he and I will be conducting together.

This hearing is part of an ongoing effort by the bipartisan Senate working group in universal access to provide health care for all Americans. As many in this room would know, Senators Chafee, Kennedy, Hatch, and I, and many others from this committee and from the Labor and Human Resources Committee have been working together now for many months to develop a bipartisan proposal.

I would say that I think it is so important that we try to do this on that basis if we can. I think we can and we should make every effort to do so.

More than ever before, this country needs a national strategy for reforming our health care system. Our health care system on the one hand is the most advanced and sophisticated in the world, if you can afford it and have access to it; but on the other hand it is failing us in two important ways.

Tens of millions of Americans are without any health insurance whatsoever or the financial resources to purchase health care services when they or their families are in severe need. Yet, at the same time, our health care system has become far and away the most expensive system in the world. It stands to reason and all the analysis that is available shows that a more efficient, and better defined, and better redesigned health care delivery system could provide care to all Americans without exception, without utilizing additional national resources.

Getting from where we are today to that better situation is the focus of our effort here today that we kick off. We are reading each day that these problems are not only with us, but getting worse. We now know that even more Americans, over 60 million each year, sometime during the year lack health insurance protection.

In Michigan this subcommittee has heard testimony from individuals who appeared as witnesses who have since died as a result of not receiving timely medical care, specifically because they had no health insurance.

Recent studies also show that the uninsured are more likely to die after entering a hospital, and less likely to have certain procedures performed when compared to those people who have insurance.

A recent study I requested from the GAO underscores the fact that the uninsured span all ages, all income levels, the whole range of employment status, ethnic groups and geographic regions. I am going to make that GAO report a part of the record today.

[The GAO report appears in the appendix.]

Senator RIEGLE. In fact, the rate of uninsured people varies across the country from a figure of 8 percent in some States to almost 30 percent among others, in the 15 largest States in the country that were looked at.

At the same time, the United States has the highest per capita health care spending of any nation. We spend over $2,000 per

capita per year on health care. And spending on the aggregate on health is approaching 12 percent of the gross national product, far exceeding that of any other nation in the world.

In fact, the high health care costs have made American business increasingly uncompetitive in the world market place and we will hear testimony about that today. It has also forced families to absorb higher out-of-pocket costs to maintain coverage; and it has led almost every thoughtful person to question the kind of value that we are getting for this massive national investment.

Encouragingly, we see that the political dynamics around this issue have changed, I think, dramatically; and all sectors of the society now recognize the need for change and are working more and more together to find solutions.

Big business, finding increasingly competitive world markets, must find ways to control health care costs. Small businesses fear government-mandated health benefits for employees and they are looking for alternatives to mandates.

State Governments are finding that health care costs are an increasingly large percentage of their budgets and in many cases they do not have the money to pay those bills. The Governors have formed a task force to develop their own recommendations on this issue and we will have a distinguished representative of that group testify as our first witness this morning.

Doctors and hospitals are concerned about the lack of adequate payment for services and they want answers to the uncompensated care problem and to see to it that people with health needs have them met.

On the insurance side, the insurers are looking for new ways to keep costs down so their customers do not move to other forms of care or to self-insurance. Health care has now become the major issue in the vast majority of collective bargaining negotiations across America. And organized labor, under the umbrella of the AFL-CIO, recently united in supporting the need to achieve universal access and significant cost containment through building on the nation's existing employer-based system. That too is a significant development and represents an important movement by that very significant group.

A majority of consumers themselves have also overwhelmingly expressed a need for substantial health care reform.

So we need to act now on these connected issues, of universal access to health care and rising health care costs, meaning reengineering the system of health care delivery to get those costs down to pay for the universal access. We have done a lot of study on these issues. But I think it is time now to end the study phase and to move forward on a health care program for all Americans.

We have asked these individuals today that will appear before us to discuss their organization's efforts in this area, and to help us as we now build a solution that will guarantee health care coverage for all Americans and at the same time control the sharply rising health care costs.

Senator Packwood?

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, thank you.

You very correctly stated the problem we face today and it is a crisis. There is no question about it. That term is often overused. But in the case of health care, both lack of coverage and the cost for those who are covered is a crisis—to those who are covered and for those who have to pay for it.

But the problem is so immense and the language used so convoluted that the public has a difficult time understanding it. I think it can be put better in a microcosm by looking at my own State of Oregon. Oregon has attempted to meet this problem head on. There are 450,000 Oregonians, about 18 percent of the population, that do not have health insurance at all; Of those, 66 percent are the working poor.

People expect or assume that Medicaid covers the poor, but it does not. In Oregon there are 120,000 men, women and children who now live below the poverty line, but are not covered by Medicaid because Oregon only covers in Medicaid 55 percent of the poverty level. And that is higher than most of the States in the union.

For example, a family of four making $6,493 or $541 a month is too "rich" to qualify for Medicaid in Oregon. And yet it would cost an average of $204 a month with a $500 deductible for this family to obtain health insurance. I would ask you: Can a family making $541 a month afford to spend $204 of it on health insurance? They clearly cannot.

But I am not sure the answer necessarily lies in rushing to a new Federal policy. We have tried Federal policies in the past. They have not ended up covering everybody. They have been more expensive than any of us ever conceived. There is yet to be any medical program we have undertaken that cost as little as we thought or hoped it might cost.

So I would suggest that Oregon is offering one approach. It is going to need some help from the Federal Government to test it in the form of a Medicaid waiver, but this is what Oregon has done. It is called the Basic Health Service Plan.

It would provide health care to all but 2 percent of Oregon's population. I want to emphasize again, 18 percent of the State currently has no health coverage at all. Oregon would provide these services through three laws. The first would expand the Medicaid program to all uninsured people with incomes below the Federal poverty line, which is $12,700 for a family of four. So Oregon is going to go from 55 percent to 100 percent of the poverty level under Medicaid.

It would also include people not eligible currently under Federal law, such as working age single adults and childless couples. About 60 percent of those that will be added through this first law are families with children, families which now have no health insurance because Medicaid is tied to welfare cash assistance.

Under this plan, the family of four that I have mentioned would not need to direct almost half of its income toward buying health insurance.

The second law—and these were all passed by the legislature last year, and they were passed as a trilogy—covers the working poor and the law mandates employers to offer all permanent employees and their dependents the same minimum benefit package that is adopted under Medicaid. It requires employers to pay 75 percent of the workers premium. We have given the businesses some tax credits to do it.

For their own coverage, the worker will pay only 25 percent of the premium to cover them, 50 percent if they want to cover dependents. Interesting, when this law passed the legislature, and this is the mandate, it had the support of both Associated Oregon Industries, which is the largest employer-based organization in the State, and the AFL-CIO. So we are well committed to trying this. And by 1994 this is to be in full effect with the coverage to be complete.

The third law provides health insurance coverage to the medically uninsurable. We estimate there about 20,000 people who are medically uninsurable. These are people with conditions that make it impossible for them to get health insurance. Oregon will share responsibility with insurers for coverage of these people through a risk pool.

Critics of the Oregon plan have thrown around the word "rationing." I tell you, that is exactly what we are doing today. When you say to somebody who in Oregon today is at 60 percent of the poverty level and you have no coverage of Medicaid at all, that is rationing. So the State has said we will go to 100 percent of the poverty level, and then we will attempt to determine in a priority order which are the more valuable and which are the less valuable medical services.

But I emphasize again, if we can get the waiver that we need from Congress to try this, we will have already put in place the other laws that will assure that at least in Oregon everybody will be entitled to a decent minimum level of medical coverage. If you want more than that, if the employer and the union want to bargain for more than that, they are perfectly free to do so. But this plan, in effect, will for the first time, I think, in any State in the union, guarantee that everyone—men, women, children, poor, working poor, rich, those who are otherwise medically uninsurable—will have access to a minimum but decent level of medical care.

I would hope the Federal Government will give Oregon a chance to experiment with this on the possibility that we do not pass some national medical plan this Congress; and at least we would have the experience of Oregon to look at, to see if, indeed, what we think will work does work and possibly could be a model for the entire country.

Thank you, Mr. Chairman.

Senator RIEGLE. Thank you, Senator Packwood.

I think it should be noted that States are making great efforts as we will be hearing here shortly from Governor Castle. I, for one, and the staff here are very interested in what Oregon is doing. I know that plan is not fully worked out yet, but it is moving in a direction.

At the same time I think you would be the first to acknowledge that we have 50 States out there and while one State may by virtue of its initiative try and succeed in making some progress here, this is a 50 State problem and we really need, however we craft it, a 50 State answer.

In my State right now, today, we have roughly a million people who are uninsured. There are 300,000 of those or more who are children. You do not have to make very many trips over to Children's Hospital here in Washington to see the nature of the extraordinary health problems that strike children. The notion of children all across the country facing critical medical needs that in many cases are not met or they get there so late and are so sick that in many cases they cannot be treated properly.

We have such a massive deployment of effort underway literally this minute in the Persian Gulf, where we have 500,000 Americans out there putting their lives on the line to meet certain objectives in that arena. At the same time, we have to recognize the fact that here at home the people in our own society with something as basic as an urgent medical need really have nowhere to turn—numbering as high in the course of a given year as 60 million people.

I sort of wonder about the level of effort that we make, sometimes, for problems on one hand versus problems on the other. But if this country is going to be strong today and strong in the future, it has to have strong people. That means that people have to be well and healthy and have access to health care.

I am very interested in what Oregon is doing. We are attempting some initiatives in Michigan as well. But the States cannot, I think, be expected by themselves to solve this problem. I think the fiscal situation alone makes that not practical and so there needs to be systemic reform—reform within the system itself.

I very much want the States and the Federal Government to work in a partnership arrangement here; and the two parties which we have set up that structure. I am convinced that that can be made to happen. I know your view and your history is along those lines. You bring everybody together around the same table and that is when you get results.

Senator PACKWOOD. Actually, I was the lead sponsor in the Senate for President Nixon's Comprehensive Health Insurance Plan, which was a mandated insurance plan in terms of theory, not any different than the other mandated plans that are now being tossed around. So the idea is not really a new idea. It certainly had good credible Republican lineage under President Nixon.

Senator RIEGLE. With that, let me call our first witness to the table. That is Governor Michael Castle who is with us this morning. Let me invite you to come on up to the witness table.

We are especially pleased to have the Governor of Delaware with us this morning testifying on behalf of the National Governors' Association. Governor Castle is serving a Vice Chairman of the Task Force on Health, which was specifically created by the Governors to address health care reform.

Let me just say at the outset that I consider this the first of many meetings that we will be holding during this Congress between those of us who carry special responsibilities in this area

within the Congress and in the Senate, and the Governors on this issue.

We have other meetings together in other settings and I know the Governors have made this a top priority because of the urgency that attaches to it. So I want to say to you today personally, and through you to your colleagues from the 50 States, that we very much want to establish a Federal/State partnership in working toward high quality, affordable health care that reaches everybody, not just some or the well healed, but every citizen in this land.

I know you had a very busy schedule today and you have made a great effort to accommodate this hearing, and we appreciate it. So we would be pleased to hear from you now.

STATEMENT OF HON. MICHAEL N. CASTLE, GOVERNOR, STATE OF DELAWARE

Governor CASTLE. Thank you very much, Mr. Chairman and Senator Packwood. I am delighted to be here to share some thoughts with you on the need to reform our health care system.

I just wanted to say something before we get into that. As an observer from not too far away, from 2 hours away, of the war in the Persian Gulf, I just want to congratulate everybody in Washington for the way this has been handled. Any loss of American or Allied lives is regrettable but, indeed, I have been very duly impressed by all I have heard and seen these many months this has been going on.

We all hope it will end soon, but this is one person from the outside speaking to two Senators on behalf of a lot of people from the outside. We thank you and congratulate you and everybody in Washington for that effort. It has been extraordinary, I believe.

Let me just say, Mr. Chairman, you used the word "partnership" and I could not endorse that more. No matter what I say today or what any other witness is going to say today, I doubt if any of us will put out the magical answers to solve the problems of health care before the sun comes down this evening if I had to guess.

That may not even happen for months or years or whatever it may be with all the studies that are going on. But partnership is the key to it. If we cannot work together, if we cannot cooperate with each other as ideas and problems and hopefully solutions, then I am afraid we will never ultimately resolve this problem.

If there is just one message I would like to leave, it is while the Governors are studying this—and I will be touching on that—we have requests on Medicaid mandates and all kinds of other concerns as a bottom line. The real bottom line is we need to understand this system, we need to understand it as a tremendous problem and we do need to work together.

Whatever the solution is, it is not going to come unless we do that. I really appreciate your words with respect to that.

Health care reform is the number one priority for the National Governor's Association, and we are committed to solving the problems that confront the health care system. I do not say that lightly. In this year, we have designated that as our number one priority; and we are doing a study, which I will be referring to, which will

come out in August. That is our major work for the course of this year.

As you well indicated in your opening statement, and Senate Packwood stated, our nation's system is near a state of crisis. We did spend in 1989 almost $600 billion on health care or 11.9 percent of our gross national product. Which in and of itself may not mean much, but it is a tremendous growth in recent years. And as you indicated it is more than $2,000 per person. I think it is $2,400 per person in this country. Most importantly, at the rate of growth, if left unchecked, this could double by the year 2000.

I would just like to give you one example of my State of Delaware. I have a 1 percent budget increase proposal for this year. In that same budget I am proposing that we increase our medical insurance payments for our employees by 15 percent and our Medicaid payments by 15 percent.

Needless to say, we had to carve other things out of the budget to accommodate those mandates and other costs that we had to put in.

As you have also indicated, we have a number who are uninsured. You said 30 percent. I have a figure of 31 million Americans, sometimes up to 37 million. I have heard higher figures. But there is undoubtedly a large percentage of our population which receives no coverage, no preventative care and at best emergency room care at the very end, which is a tremendous problem for the country as well.

We know that the consequences of such costs are severe. Many employers must cut employee benefits and deny coverage to dependents and Governors, as I have indicated, are employers too. So we see it from that perspective as well. And we are confronted with the exact same challenges.

The dire health care situation in the country led the Governors to appeal to Congress, which you may recall, and the administration in August of 1989 to haunt the enactment of any further Medicaid mandates for 2 years while we work to find long-term solutions.

Since the passage of that resolution, we have, as Governors, moved aggressively to fulfill our commitment by establishing the health care task force which is scheduled to produce two products by this August.

First, a detailed report on State options to increase access to health care and control costs; and second, a policy statement focusing on key reform issues requiring Federal action. Governors, as you both well know, currently hold a number of important policy levers that we think we can use more efficiently and effectively to increase both access and control costs in our States.

Not only do we finance care directly through Medicaid and public health, but we also regulate insurance, license health care providers and facilities, and have had some experience in the allocation of capital resources.

The report that we will be issuing this summer will identify incremental and comprehensive ways States can restructure their health care financing and delivery systems to emphasize prevention, better serve the working uninsured and increase access for the nonworking population.

The report will also feature a wide range of options for cost containment, including incremental discreet strategies, such as managed care and innovative strategies, including State level, all payor systems, which is really negotiated rate setting, and global budgeting.

And finally, the report will contain suggestions on Federal action to help States implement such reforms. There will be a policy to accompany the report which will make specific recommendations for Federal action to restructure our health care system, adjusting the future direction of the Medicaid program, changes in insurance practices and small market reforms.

Now having said that, we do have to discuss the subject as Medicaid, which as you know is sort of a nemesis of the Governors. And it is sort of a difficult situation, because that is one of the opportunities to expand health care. On the other hand, it is what is destructive of the budget of the Governors, as you well know in Michigan at this point with the budget problems which exist there.

So I touch on these things realizing it is a difficult balance in terms of what we want to do, both Governors and members of Congress, and the problems that we have out there.

Escalating costs and limited access to health care have had a profound impact on Medicaid. Medicaid has become a catchall program serving a wide variety of special populations. I do not think I have to detail that for you. It started in 1965 as a simple way of aiding those who could not afford health care and from there it has gone into all kinds of other populations—two-thirds of which is for home care, for nursing homes and that kind of thing. It has clearly lost its original purpose, if not its defined purpose.

The expansions have cost big money. The mandates enacted over the last 4 years alone will cost States $17.4 billion between 1991 and 1995 and Medicaid is now the fastest growing portion of the State budget it is projected to consume 17 percent of State budgets by 1995. That is, again, on a very rapidly increasing rate.

As the Governors wrestle with the long-term role of Medicaid in a restructured health care system, we are discussing the following concepts:

Should Medicare benefits be enhanced to circumvent cost-shifting in Medicaid? Would it be more appropriate to move long-term care out of Medicaid and establish a separate program which can better serve the social service and medical needs of individuals in need of long-term care? Would it be more appropriate to establish a similar, separate program for other specific Medicaid populations? Should the link between Medicaid and welfare be broken in favor of a publicly funded health insurance program to meet the health care needs of diverse populations? Should States not have the flexibility under Medicaid to develop and use the same cost-saving strategies employed by the private sector in Medicare?

Recognizing that these problems are difficult, it must be considered in the context of large system reform. At our winter meeting the Governors also approved a short-term Medicaid policy, calling on Congress to make the following changes in Medicaid:

Delay the mandated implementation of the 1990 Medicaid mandates. They could be left option, but the mandated portion is what we would like to eliminate. Allow States to delay implementation

of Medicaid changes until the Health Care Financing Administration has published final regulations. Protect the States complete authority to raise funds to match Federal Medicaid dollars without Federal restriction and to promote cost control efficiency. Encourage States to continue innovations in provider payment systems.

In addition, we ask for relief from three particularly troublesome mandates enacted in the last 4 years. First, mandated Medicaid payment of cost-sharing requirements for low-income Medicare beneficiaries. Second, nursing home reform requirements contained in the 1987 Budget Reconciliation Act. And third, early periodic screening, diagnostic and treatment mandates that supersede State Medicaid plans.

Mr. Chairman, the Governors are in agreement that our health care system must be reformed. We are on the front lines and see first what the effects are on our population. I would just like to give you an example of something we have run into in Delaware. It is anecdotal and it is perhaps not universally applicable, but it gives you some idea, I think, of what we are dealing with.

We have three counties in Delaware. I know that sounds small, but that is it. One of those counties is Sussex County, where Rehobeth Beach is, which a lot of people in this room know. But as you drive through to get to Rehobeth Beach you will see the rural portion of it, particularly at the initial western stages of Sussex County.

In one portion there, there are five doctors who provide prenatal and maternity services for about 800 births each year. Of those deliveries about 400 are covered by third-party insurance—280 are uninsured and 120 have Medicaid coverage. Until last summer we contracted with those doctors for the provision of prenatal and delivery services.

They terminated their contracts during the summer and left the uninsured portion of the County with no access to medical prenatal services. In December in one town in that County four infants died. We cannot be sure, really, that there is a direct correlation. I cannot make that case here between the lack of prenatal care and infant deaths in this instance, but I cannot help but wonder if the outcome might have been different if that care had been there.

Interesting enough, Delaware, which is a fairly high per capita income State has one of the high infant mortality rates in the country. Obviously, problems like this add to that. Let me just suggest, this is not just a Federal problem. We changed our payment system which was complex and obviously it is a question of how much we reimburse an issue such as that.

But nonetheless, it points out the lack of coverage that comprehensively our system provides today.

Senator RIEGLE. Let me just ask you, that is a very powerful illustration and I am sure we can find other examples in the other States just like this because of the difficulty of maintaining coverage in some areas. Have you been able to find a way to reestablish coverage or are these doctors still in that same status of not providing this care or has a means been found to get care to these people?

Governor CASTLE. We are doing two things. One is, we are negotiating hard. Of course, Delaware is a small State, so we are individ-

ually negotiating very hard with the individual doctors to see what we can do. One of them—in fact, I just sent a thank you note to her—indicated that she would start to cover again and has become involved.

We are also—and this, by the way has not been announced in Delaware—looking at the possibility of increasing the reimbursement. There is a normal reimbursement, as you may recall. They look at the standard rates. Ours is 50 percent in the State of Delaware. We feel that if it was higher, that perhaps there would be more willingness to continue coverage or to come into the coverage as far as doctors are concerned.

So we are looking at increasing that from our own perspective. We think that is important as well.

We have also, by the way, experimented with clinics. Another anecdote in another County, the one to the north of that, in Kent County, there is a center which was started, the Williams Center for underserved mothers, if you will, and infants. And 50 percent of the births in the only hospital in that County now come from that clinic, which is run by our Department of Health and Social Services, which is an astounding number.

I mean, I assume that that 50 percent was basically totally underserved before we started this clinic. This has cut into our infant mortality greatly. I am a believer in the clinic approach in many cases. Because I think if it works, word gets out on the street and people will come to that.

Just another example I was going to cite anyhow, we have started in, I think, four of our high schools now—we very much want to expand it—we have 26 or 27 high schools—although it is very expensive—an adolescent health clinic, which is not there to preach birth control or whatever it may be. It is really there to provide health control and to really talk to kids about what their problems are.

They have discovered all kinds of problems, including cancer problems and problems with siblings, and probably a number of things that probably never would have been discovered with again a very underserved population because we were able to put the health care there.

I think there is no question that I think if we are going to solve these problems, we have to do these kinds of things and bring the care into the very systems, be it a school or a place where people can go and that they know about it. It is a little more than just numbers, just Medicaid numbers and health numbers or whatever it may be. It is a question of bringing the services properly to the people involved. I am a strong believer in that student service.

Senator RIEGLE. Well, I like the sound of it, too. Of course, the problem is that that involves spending public money. So that becomes, in effect, a public problem.

Governor CASTLE. That is correct.

Senator RIEGLE. But I gather that you are testifying that public programs, like the clinic and like this high school program, appear to you to be cost effective and maybe the best alternative. It is the alternative you turn to in the absence of any other, I take it?

Governor CASTLE. It is.

You know, in the terms of the cost effectiveness or the cost, there is an up-front cost. It is a question of who would pay it. Does the Federal Government pay it; does the State Government pay it? But God only knows, in the case of infant mortality or in the case of severe problems at birth, if those problems happen, the costs—and I have seen the figures, I just do not have them in front of me; we have all seen them—it is astronomical what it costs to keep somebody who is impacted at birth going health wise throughout their entire life.

It may cost literally hundreds of thousands, into the millions of dollars, for one case, depending on what happens. I happen to believe that any money that we spend in that particular area is ultimately a cost saving. It is an up front cost, but a cost saving.

I think as we redevelop our system, we need to pay some attention to that. As you know, we spend a tremendous amount in the last year of life. And, obviously, I think the first year of life would probably be, all in all an expenditure we should be looking at in terms of where some of our costs should go.

That is a little beyond what I am testifying to, but I think it is vitally important that we understand that in this country.

Senator RIEGLE. Well, I appreciate that. You are out there on the firing line. I mean one of the great values that Governors have, I think, is the source of information and guidance to us, is the fact that you are confronted with having to solve these problems directly within your State and you have found a means and it is important that we discuss it some.

Governor CASTLE. I must say, I mean, we struggle, too. You know, these things are not simple. I think it is why we have decided in this report that we are going to issue in August that instead of coming up with one comprehensive solution—a Canadian system or German system or whatever it may be—we are going to do a series of State solutions. We are going to try to make all of the States and Governors understand what all those solutions are out there, be they the organ plan that Senator Packwood referred to or some plan in some other State or whatever it may be, and try to put those together to see what we can do.

We then will probably look at a more comprehensive plan. I have no doubt that it will be a Federal/State plan. You stated that in your opening. I believe that completely. That it will have to be something of that ilk. There is no way in the world, I do not think the Federal Government can do it all or the States can do it all. You know, we really do need to work together.

Right now we seem to be headed in the direction of expanding Medicaid and solving it that way. I would just ask for flexibility in that. I am not sure that continuous expansions of Medicaid with mandates because the States have not done what they should do is really the correct answer in terms of providing either universal health care coverage or even targeting in the right areas.

I would suggest that we may need more flexibility than that before it is all said and done.

Senator RIEGLE. Well, that is an excellent set of comments and I want to ask you some questions.

Senator Danforth is a member of the working group. Let me just ask, Senator Danforth, do you have any opening comments you would like to make at this point?

Senator DANFORTH. No, I do not, Mr. Chairman.

Senator RIEGLE. Let me ask you several things here. You are in your second term as Governor.

Governor CASTLE. Yes.

Senator RIEGLE. So you have been around the track in dealing with these problems and are not newly confronting them. When you look at all the different issues that you are having to contend with right now in Delaware, is the health care problem as tough as any?

I mean, in terms of where you put it on your operational priorities, is it number one, is it number two? Can you give us some sense as to what this means to a Governor today who has his or her hands full with the whole host of activities?

Governor CASTLE. For me as a Governor running a State it is very, very high. For instance, as I have already indicated, when I put together my budget the first thing I have to do is look at the health care costs, Medicaid and our Blue Cross coverage for our employees, and figure that out before I can do anything else, because it is a mandated cost. So it becomes an immediate budget cost.

States worry about their budgets ahead of almost anything else. Because as you know, we have to balance our budgets. It is also a problem in terms of our just providing health in the State. I do worry about being a high State in infant mortality. We are still high, by the way, even though we have addressed the problem somewhat.

We worry about hearing about children who are older than a year who have problems. You worry about just reading about lack of health care coverage. Newspapers tend to cover this particular subject. It is sort of an easy subject if something goes wrong out there. So we worry about that a tremendous amount.

I hear from constituents about that. On the other hand, having said that, and I do not know if I would rate it first or not, I suppose the economy in a sense is first at this point, but this is close behind. It is up there with education and almost every other program we have in our States.

But to the average person—and by the average person, I mean maybe 70 or 80 percent of our population—it is really not a matter of grave concern. They may work for the Dupont Company or even a smaller employer who provides their health insurance. They do not think about the cost of what the hospitals charge you or the doctors charge, and they do not think about infant mortality, particularly, because they are getting very good care from their gynecologist, obstetrician, whatever it may be. And, therefore, it is not a concern to them.

I do not see in this country that the awareness of the health care problem is as great as it should be. I think there is a much greater awareness of other problems because the average middle American, which most of us are, is not impacted by this, because we have that coverage. We are not in that group of 40 million or 35 million who

do not have that coverage. And that group does not have as much of a voice as do the people we may see on a regular basis.

So it tends to be an issue which is an iceberg issue, if you will. The tip is above the ground. You are seeing it, and I am seeing it, and there are experts out there who are seeing it. I think the media is seeing it. But I am not sure it is a gut reaction from the people yet that, indeed, there are people who are suffering because of this.

I think the fairest comparisons are what other countries are doing versus what the United States is doing. I mean our infant mortality rate, compared to almost Third-World countries, is still pretty high. That is very embarrassing. In terms of approval rating, I think for instance in Canada—to the extent that you believe polls—their approval of their health care system is three or four or five times higher than the approval rating of our health care system.

So there is some grumbling out there. But I do not think it has quite gotten to the fever pitch that it is going to really galvanize everybody to do something about it. I think it is our responsibility to try to lead in that area if we can.

Senator RIEGLE. Now you have given us a pretty good sense for the feeling and the situation in your State. I am correct, I think, in noting that the Governors as a whole have decided to make this issue the top issue for the Governors; is that correct?

Governor CASTLE. Yes. That is very correct. Just so you understand, the Governors have two meetings a year of three days each and the NGA Chairman is Booth Gardner from the State of Washington.

Senator RIEGLE. Yes.

Governor CASTLE. And since Lamar Alexander, I guess back in 1985 when he was the Chair, each Governor has chosen a particular subject and made that the theme of what they wanted to do. Bill Clinton and I are the vice chairs and he is the chair of the committee which is working on health care. That is our theme for this year. Our final meeting is in Seattle, WA, in August. That is when the report I referred to will come out with our specific recommendations.

We have issued interim reports. We have had hearings. We have sent over petitions to you concerning the mandates and trying to get us some relief in that area. But our final health care report with our specific recommendations will be issued in August of this year.

Senator RIEGLE. Now as I understand it, the original plan was to try to do it sooner than that, but we have a lot of new Governors who are participating, and want to participate, and I think that has apparently stretched the time table out a little bit.

With respect to the interest groups that you talk to in the State, when you talk to employers, you talk with insurance companies, you talk with doctors. I assume you have some of the same hospital problems we do all over the country where emergency rooms are overloaded and many hospitals are trying to close their emergency rooms because that is just one form this problem is taking.

Are you finding, as I have found, that all of the basic parties of interest are now pretty much lined up in the same direction, that

they want the system overhauled? I mean they may have some differences of opinion on how to do it. But I am hearing a unanimity of expression from all of the parties of interest saying, "Hey, look, we cannot wait any longer for some kind of a fundamental restructuring here because we are all being hurt." Are you hearing that?

Governor CASTLE. Yes. I am hearing it. But, you know, I do have to point out one example. I was trying to find something here, too—one example of something that happened to me last year. I met with the directors of our medical society in the State of Delaware. I raised the issue of the same county I referred to earlier, and I indicated that, you know, if there are not doctors available to serve there or will not provide the service if they are there, then in my judgment we are better off having nurse practitioners or somebody else who can provide some form of medical service.

And a doctor there said, "I do not agree with that." He said, basically, "People should get the best medical care they can and that is provided by doctors." And I said the point I am making is that there is no doctor there who will give these people service and they are better having some level of care.

He was actually a little bit indignant about the fact that somebody other than doctors would be providing that care. So I think he recognized there is a problem, but he is unwilling to address it in terms of the flexibility of something else we can do.

I am not trying to fault all of the different people, the different groups—the hospitals, the doctors, whatever it may be—but the bottom line is that most people—and it may be true of Governors too—who are trying to solve these particular problems are still trying to solve it with an eye towards their own situation. It is not sort of a universal. There is an absolute problem, let us throw it all in the middle and see if we can work it out.

That is my concern. I think we need a little more self-sacrifice, if you will, in terms of where we are going if we are going to resolve this problem.

Senator RIEGLE. Senator Danforth?

Senator DANFORTH. Governor, thank you very much. Would you agree with me that in whatever things we do in Congress with respect to health care, cost containment must be, must be, a component of whatever program we come up with?

Governor CASTLE. I could not agree more. My judgment is that every single program you hand down to the States should have some revision for flexibility in terms of what cost containment we can put in. Is there an alternative?

Do not mandate with a specific cost without putting something in there saying, "If you can find a less expensive way we will give you a waive or whatever it may be in order to address the issues of cost containment."

This and higher education, as you well know, are the two that are just really eating up State budgets and Federal budgets to some great degree. I mean they are going up much higher than the rate of inflation. We absolutely have to do something about the cost containment component. I think we need to do it at every step. I think all the Federal programs, all the State programs, all these discussions that we have before the Senate today, whatever they may be,

need to have elements and components of what we can do in cost containment.

Yes, I agree with you.

Senator DANFORTH. And you want maximum flexibility for the States. Would the Canadian system not give you maximum flexibility? In other words, the Federal Government would say, in effect, "Look, we can only spend so much money on health care and here it is; you decide what to do with it."

Governor CASTLE. I am a little closer to the Canadian system than are some other Governors. So I have to be careful speaking for myself first as the Governors on this. I am not that familiar with all the details of what they do.

But clearly, a comprehensive national system like that is at least worth exploring. Anyone who says it is not just has not been following health care in the last 15 years. I am not sure that we are ready for that now. But then again, you are not ready for a lot of things until they happen. Perhaps it is just something that needs to happen.

I do not think that the Medicaid base system has worked particularly well. If we are going to continue that system, I think we do need to build in a lot more flexibility, if you will, in terms of the cost containment that we just discussed or in terms of flexibility how to get services out to people.

Before I would sign off on the Canadian system, I would like to see a number of experts who could really look at it and show how it would work in the United States. There is the whole concept of just a guaranteed system, based on, the fact that we are putting $600 million in health care. Let us get rid of some components of it, be it the private insurers or whatever. Put $600 million truly into health care and whack it up in whatever ways are possible, which is akin to any of these national systems, I suppose.

I cannot sit here and say I absolutely endorse it, but I sure as heck endorse the concept of looking at it in similar type systems.

Senator DANFORTH. It seems to me that if we are talking about cost containment there are basically two ways to do it as far as the Federal Government is concerned. One is to say, here is how much money we are going to spend. That is it.

Governor CASTLE. That is correct.

Senator DANFORTH. That is basically what budgeting does in any context in Government. You set a number and you have to hit it. The other way to contain costs is for us to have a very elaborate system of regulation.

What I hear you saying is that you would rather have us just say, "Look, here is the money," than to have us say, "Here is the elaborate set of regulations we are going to hand in."

Governor CASTLE. That is, I guess, to some degree correct. It may be a bit of an oversimplification. I think that the regulation for the most part should be at the State level. I think it is sort of easier there in terms of the components and you can introduce the flexibility there, if you will.

But I do understand what you are saying about the total cost. I have always believed this, that one of the problems in the American health care system is that scientifically we are so advanced over most other countries that we tend to come up with diagnostic

equipment and other methodologies of solving problems that we all tend to get the idea that we can have a new heart or kidney or whatever it may be almost on demand. It is not quite that simple.

There are certain processes that are very, very expensive. I am afraid that our insurance system may have led us to create companies that do MRI and other things that are very expensive perhaps more than we need. Most of these national health care systems, as I understand it, do not give anywhere near the same health care coverage that the United States does.

One of the areas that America would have to cut back on if we ever went to a system like that is the available medical coverage unless there is some premium for those who wanted to pay more. We have to understand this, that you probably would not get the same coverage in a Canadian system that we get in America today.

I am not sure if the American public is ready for that either. I mean that is one of the factors that we have to consider in that kind of a system.

Senator DANFORTH. That is right.

Governor CASTLE. Yes, sir.

Senator DANFORTH. It is going to be a very difficult political argument, isn't it? Unless we are going to spend an infinite amount of money for anything for everybody then it seems to me that there are two ways to go. One is to say, "look, there are thirty-some odd million Americans who now have no insurance and we have to expand the number of people who are covered."

Or, on the other hand we could say, "we are going to provide gold-plated care, but not for everybody." That is a hard choice. I mean that is a very, very difficult political decision. Because most people say, "Hey, if I am sick, I want the best." You know, you can turn on your local television almost any night and you will see some heart wrenching story about somebody who absolutely needs some treatment and how are we going to afford this, you know, $400,000 or so for whatever the treatment happens to be.

It seems to me that the difficult choice is going to be how to spend a limited amount of money. If we are going to expand the number of people who are covered then, unless we are going to have the top go off of the costs, there has to be some way of saying, "no, there are certain things that we in Government are not going to provide you."

Governor CASTLE. I agree with everything you said. I would like to add one additional thought, if I may. That is, I think there could be within this $600 billion that we spend now more efficiency in terms of how we spend it, which could help with the expansion. Not probably to the extent of covering an additional 35 or 40 million people, but I do think there are some cost excesses. I know; I don't think. I mean you see it. There are cost excesses in today's system. So it is probably a combination of the two that could make the difference.

Senator DANFORTH. Let me ask you about how well States are equipped to make the hard political choices. I think there is a lot to be said for allowing a lot of latitude in the States. But some people have questioned so-called State options where various interest groups go to the State legislators and they say, "Look, if we are going to have any kind of health insurance in our State, we have to

cover podiatrists or we have to cover chiropractors or we have to cover this group or that group."

And the tendancy of politicians is to be popular with whoever comes through the door and to say, "Oh, yes; you are right." A lot of people have commented on the so-called State mandates. How should we handle that? I mean is that sort of a model that we can somehow avoid in the future?

Governor CASTLE. I think we can avoid it, Senator. I believe there has been a shift at the State level and perhaps in national awareness in terms of health care.

As you know, under the Medicaid system with expansions, I have a chart that may have come from the Federal Government that is a yellow chart that shows all the States and it shows all those services; and it has a little bullet if you provide that service.

I was amazed at the number of services. We are fairly limited in Delaware. We have been, perhaps, too conservative. We have started to expand it more in recent years. But there are some 40 or 45 services. You know, you have indicated some of them. But be it a chiropractor or basic dental services or whatever it may be that can be covered, then there is tremendous political pressure from those groups who may have contributed to candidates, I might add, in the General Assembly to include our particular service under your Medicaid policy.

You do that and you get into this tremendous expanding area that is beyond, perhaps, what we should be doing in health care today. So some of the State approved mandates have proven to be really burdensome to the cost system. I think what I see happening among Governors—and I could not have said this two or 3 years ago, but I will say it today—is that you see a number of Governors who realize that health care is one of their top issues, be it one, two, three, four. Whatever, it is one of the ones you talk about on a regular basis.

It is one that we need to do something about. As a result, you see Oregon—and Senator Packwood before you came in spoke to this subject—they have adopted the first really universal system that appears to be in place in the country. It is still to be judged but nonetheless it is there.

We in Delaware increased our cigarette taxes by 10 cents last year to try to help with this. We have not been able to spend it all on our indigent health care programs, but the legislature did that. There was an awareness and they did it.

So there is a much greater awareness of providing health care more universally and specifically better than there was in the past. I would trust the States more in 1991 than I would have in 1985 or even 1988 with respect to the ability to make decisions which are in the general improvement area of health care, and perhaps to understand better what these mandates mean.

Does it really mean that we are helping people who need help or does it just mean that we are helping some group who wants to be reimbursed for the services which are being provided.

This is really complex stuff. I have to tell you that I have worked on this in NGA almost since I have been there in one of the particular groups that we have in NGS; and I still, every time I read

something on this, I have to ask questions, look things up. It is very complex.

I think one of the good things that we could do is to try to make it a little simpler for legislators, Governors, perhaps Senators and staff in terms of understanding it all as we come to a solution.

Senator DANFORTH. But I must say with all due respect that I think it is very complex, too. But I think that the hard issues——

Governor CASTLE. The hard decisions.

Senator DANFORTH. That is right.

Unless we just want to, as we often do here in the Senate Finance Committee when budget time comes, we turn the decisions over to the experts. Marina Weiss and her staff come back with sheaves of papers with very detailed minor little changes.

But I think that if we really get to the question, what to do about health care and how to afford it and how to contain the cost, it is no longer a matter of saying, "Okay, this is terribly complex, nobody can understand it; let us turn it over to the experts." It requires some fundamental choices which most people in the country are going to understand and feel very strongly about.

My question is: Are we prepared to make the kinds of decisions which will really upset people?

Governor CASTLE. The answer is, we have to be. I mean I agree completely with your supposition. I absolutely believe that this country and the persons or the people running it need to make the decisions at the Federal and the State level. You are right.

The actual decisions are not that complex. You had better understand the complexity behind it. Somebody had better be able to detail exactly what the impact is. But the answer is we have unserved, underserved, and maybe overserved in this country today; and we need to look at some balance to provide for at least basic service for everybody.

That is going to take some tough answers. Because I do not for a minute believe that the amount of money we are spending now could be used as an umbrella to incorporate the extra 35 million people. I think there would have to be some, perhaps, cost expansion and certainly a systemic change. I believe we need to understand that and to do it.

I think you are right.

Senator DANFORTH. There have been a lot of comments on how much we are spending in this country compared to other countries and it is just unbelievable. I do not think that this constant progression in the cost of health care is something that we can put up with very long unless we are going to say, "Look, health care is the be all and end all in this country; and everything else is secondary or tertiary to health care."

So if we are going to broaden it, we are going to have to say that certain kinds of treatment, even some very popular kinds of treatment, are just not going to be provided by the taxpayer. Maybe somebody else wants to provide them, but the taxpayer is not going to provide them.

Let me just ask you one other question. I have taken too much time and I apologize, Mr. Chairman.

Senator RIEGLE. Take the time you need.

Senator DANFORTH. Well, just one other. One way to deal with the problem for us politicians, whether we are at the Federal level or the State level is to say, "Look, this is all too hard. It is just too hard for us." And we do not want to say no to anybody. We do not want to tell people, you know, that they cannot have basic care. We do not want to tell people that they cannot have gold-plated care.

We do not want to tell chiropractors that they cannot participate or will not be required to be participants in programs. We do not want to say no to anybody. And, therefore, we are going to do something entirely different. We are going to make somebody else hold this back. And that is a possibility.

We could simply say, "Well, employers must do for their employees whatever, whatever we require them to do." Is this something that you would support or that the Governor's Association would support?

Governor CASTLE. Well, I certainly do not want to speak for all the Governors at this point because we have not come to a conclusion on that. But I do not necessarily believe that a mandated employer-based system is necessarily the right answer. I think that has great implications for some of the smaller employers.

I am not thinking so much of the large service industries so much as I am the very small employers who struggle with some of that as well. I am not an expert on this. I mean if you get into tax credits and various thing you could do, yes, there is probably something that could be done. I think that employers probably need to be a part of whatever the answer is, unless we go to a universal health care system, if you will.

But I do not think the Governors at this point are ready to recommend and say that this should be an entirely employer-based system. First of all, you have the group that fall out of employment altogether, the 5 percent or 6 percent who fall out of it altogether, although you could have some tax that would cover them too I suppose.

I would not suggest not looking at that, at least as a partial or full solution. But I do not think we are ready to recommend that that is the solution to it.

I must also say that I agree with you on these costs. I mean one of the things I said in my testimony is that Medicaid mandates are just killers to State budgets. I am not sure entirely how much they really add to the extra service. I mean we have to do something in this country to stand up to people providing health care and say that costs must be held back.

If we have to look at eliminating medical malpractice or diminishing it in some way, if we have to look at putting some lids on things, I mean we just have to look at all of those solutions. I mean we cannot continue to have these cost increases or you are going to go broke and we are going to go broke. Probably together we are all going to go down the tubes here in the next ten years or so if we do not do something about that.

I could not agree more with you on the basic cost system. It has to be choked back some way or another.

Senator DANFORTH. And you think malpractice reform is a part of it?

Governor CASTLE. I think malpractice reform is absolutely a part of it.

Senator DANFORTH. Good for you.

Governor CASTLE. Absolutely.

Senator DANFORTH. Thank you, Mr. Chairman.

Governor CASTLE. I am a lawyer, too, by the way.

Senator DANFORTH. So am I.

Senator RIEGLE. Well, I think the discussion is right on target. That is, you have to capture all of these elements in one equation and adjust them together if we are going to get this done.

I also am inclined to think, Senator Danforth, that in listening to the discussion, once we can capture this whole system and try to rationalize it and get more cost effectiveness into it, that one of the things it starts to do is it forces the question of healthful living.

There are an awful lot of our health care costs that is devoted to people who smoke, and who do not eat properly, and who don't exercise, and who drink too much and use drugs and thing of that kind. So I think as part of the effort to get good health established, as these questions are forced one-by-one, they lead back into other basic questions having to do with the fact that an awful lot of people in our society do not take very good care of themselves and think that there is a quick fix down the line in the way of some medical procedure that can undo other problems.

It is sort of the analog of prenatal care. If you are providing adequate prenatal care and you keep an infant out of an incubator for 90 days you save $50,000 or more. There are a lot of ways to take, I think, and once we get the focus on this problem and reengineer it to induce in the country a level of awareness and responsibility that I think also has to be part of the answer.

Our problem has been that we have sidestepped the debate for so long that we really have not come to terms with it. We assume that there is a way to push the problem off somewhere and that it somehow will take care of itself.

I think it is significant in that vein to note that the last Surgeon General we had made a major point out of the smoking problem. Our current Secretary of Health and Human Services has made a major statement about that. He is a doctor as well.

But, you know, these are not ideas. One assumes these are competent professionals who have to look after the health profile of the country and who have come back and said, "You know, you have a major problem in this area—a self-created health problem that we can presumably do something about."

That is another way to solve this cost explosion problem, if we can keep people from getting emphysema or heart disease or other things that come. We have a smoker up there in the front row who is a little sheepish right now.

Governor CASTLE. That is right. We had a little discussion about this. We caught that before we came over here.

Senator RIEGLE. We cannot afford your emphysema, you know, as the practical matter, nor can State Government.

So these are important questions in terms of getting a new system built and put in place so everybody gets basic health care and protection when they have urgent health needs arise. But there is also a responsibility here, I think, on the part of all of us

to get the focus on the part of the problem that has to do with not paying sufficiently to things that are causing health problems that could be avoided.

Horrendous expense—I do not know what would be an accurate figure, but my guess would be that probably 20 percent of the cost in the health care system right now relates to things that are avoidable with more healthful living.

Governor CASTLE. If I could just comment on that, Mr. Chairman, if I may, sir.

I just could not agree with you more. We did not touch on this before. But I told our staff here when we start our report, I would like to start it with a healthy lifestyle section, emphasizing that even before you get into the health issues.

We have seen it in my State. Again, an anecdotal example of what we have done. But we had a tremendous cancer and heart problem. We started to look into it. Was it medical care? You know, was it something in our water, whatever it may be? Well, it turns out that most people concluded it was mostly a question of lifestyle, a question of smoking, obesity, if you will. I mean, tobacco, alcohol, and eating too much, and not staying in shape, and not using seat belts, and not wearing helmets on motorcycles.

I mean, these lifestyle decisions have a tremendous impact on health in this country, not only on health care costs but on how good our lives are going to be. Are we going to get hurt in an accident? Are we going to smoke and get emphysema and not be able to live our lives fully, or whatever it may be?

We have, like almost every other State, put together a Committee to sort of be the cheerleader in this area. We started to ban smoking in public buildings. We have a smokeout conference coming up to sort of underline all of this.

I could not agree with you more. I just think this country needs to lift the awareness of what these various substances, well beyond drugs, can do to adversely impact all of us. Most of these are a matter of choice. So it is a matter of persuasion, although to some degree we are eliminating smoking in public areas. But it is a question of persuasion.

I think that all of us need to stress that to make America a healthier country.

Senator RIEGLE. Thank you very much for your testimony. We look forward to working with you and the other Governors. I think our partnership is key to getting this job done, soon rather than at some distant point down the road.

Governor CASTLE. Thank you, Mr. Chairman. I agree with you. I think the partnership is more important than any specific recommendation we are going to make today or any time in the near future. If we continue to work together, I am convinced we can resolve this one.

Senator RIEGLE. Well, it is my attention to do so and we will do so.

Governor CASTLE. Thank you, sir.

Senator RIEGLE. Very good. Thank you.

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

Senator RIEGLE. Let me now excuse Governor Castle and invite our next two witnesses who are representing the business community—Mr. Robert S. Miller, Jr., Steve Miller, who is here from my home State of Michigan, and who serves as the Vice Chairman of the Chrysler Corporation; and Mr. Jeffrey Joseph, who is the Vice President for Domestic Policy of the U.S. Chamber of Commerce.

I might say that both of these witnesses participate in a variety of coalition work efforts that have been formed to address these problems. And so they bring, I think, a view that is a more far-reaching one in the sense that it reflects the thinking and the observations of a number of entities other than just their very own immediate company or group affiliation.

I want to say, before they testify, that we would have the labor movement here today to testify, as well, on a panel or even as part of this panel, but they have just taken a rather dramatic step in their meeting in Florida within the last week on the health care issue, and it marks a change in their position.

So they have not yet had time to put their testimony together in a real-time form. So we will have them at another time; and I just want to note that.

But, Mr. Miller, we are very pleased to have you here today; and hope you are going to tell us we are selling a few Chryslers these days, among other things. We would be pleased to hear from you now.

STATEMENT OF ROBERT S. MILLER, JR., VICE CHAIRMAN, CHRYSLER CORPORATION, HIGHLAND PARK, MI

Mr. MILLER. In answer to your question, darn few.

Thank you, Senator Riegle. It is a pleasure. I am here today representing Chrysler Corporation. I am the vice chairman of Chrysler. We are one of those that Senator Danforth was referring to, talking about who is holding the bag here. We are paying close to a billion dollars a year for health care which is a significant cost of the Chrysler Corporation. We are a major employer in Michigan, which is our State; and in Senator Danforth's State; and, indeed, in Governor Castle's State as well.

Besides my perspective as an employer and billpayer, I am a member of the Board of Directors of Beaumont Hospital, a major hospital in the Detroit area; and from that perspective I have seen costs shifting and the coping with the cost issues firsthand. And finally, as a native Oregonian would have a familiarity with the Oregon plan, I have a brother who is in the Oregon legislature and helped to shape that legislation; and my own son works as a staffer in the Oregon legislature. So I have a close family interest in what is going on in that scene.

I appreciate the opportunity to be here to speak. Clearly, as you have said, and as we all recognize, health care spending is out of control. If we compare ourselves to our major trading partners in West Germany and Japan, we are overspending on the order of a quarter trillion a year, which could be better spent within our economy, I think we would all agree.

This is an issue of competitiveness. There is a dramatic difference between U.S. and foreign health care costs that is damaging

to competition. Foreign auto makers enjoy a $300 to $500 per car advantage due to health care costs alone. These excessive costs also reduce the consumer disposable income, and that hurts all of American business.

Those involved in competitive markets like the automobile business cannot raise prices at will to recoup higher health costs, instead what results as a classic squeeze on profitability. Lower profits reduce the funds which could otherwise be invested in research, new products and job creation. Lower profitability also reduces our tax revenues for investment by government and infrastructure improvement.

Chrysler is convinced that to accomplish overall health system reform, coordination between the public and private sectors is required. We cannot simply continue doing what is happening now, where we pit large buyers against small buyers of health services; and permit the public sector, which is the only one empowered to pass laws and shift costs, to operate its enormous health plans without regard to impact on private sector payors.

Sadly, however, because we do not have a health policy in this country, coordination is lacking. As a result, the public sector has the opportunity to control its spending by taking steps which lead to costs being shifted to private sector payors. For example, Medicaid today covers only 40 percent of the poor. And for those it does cover, it pays doctors only 66 percent of Medicare rates.

Some private sector employers are doing the same thing. Clearly, for example, a disproportionate share of employer-paid health costs is borne by the manufacturing sector of the economy to the benefit of the service sector, and that exacerbates our competitive problem with foreign firms.

The Federal Government can help chart the course for a rational health policy for America in one of two general ways. Either by establishing overall group rules within which a public/private partnership can work to achieve our Nation's health care objectives or by establishing a fully publicly financed and administered plan. We do not see any other solutions at this time which show promise for success.

Our objectives should be a health system within which the necessary health care needs of all citizens are met. A system which consumes resources prudently, balances spending on health with other national priorities, spreads costs over the broadest possible base, and does not disproportionately impact any segment of the economy, and finally a system which exists in the context of continuous quality improvement.

To accomplish these objectives we need equity among payers. This requires a process for a determination of fair provider fees, with such fees applicable to all public and private sector payors. We need equity within the economy. If we are to rely on employer-financing in the future, all employers must participate. This can be done without harming weak or deterring start-up enterprises and without encumbering established employers with unreasonable costs.

To help accomplish this within a public/private reform strategy, any employer or individual should have the option to pay a tax no

greater than the cost of a community-rated premium, thus permitting enrollment in a publicly administered plan.

This will help assure costs are spread across the broadest possible base in our economy and that no sector of the economy, or no employer, bears a disproportionately large share of expenditures.

We need fiscal integrity. No nation on earth has embarked on a program to provide all citizens access to health care without concurrently adopting a strategy to control aggregate national health care spending.

Such management of spending should extend not only to spending for health care services, but spending for capital items and graduate medical education as well. This is critical.

Barring change, health care costs will exceed $2 trillion by the year 2000 and will absorb 20% of the Nation's GNP. Health costs are growing far faster than family income, business income, local, State or Federal Government income. The result, a steady reduction in citizen's standard of living as health care absorbs more and more of our citizens and our nation's resources and saps the strength of its businesses.

This is happening without a vote of the people, because our nation lacks a health policy, lacks a system to address the problem. This is the result of inaction. The sooner our society rises to this challenge, the sooner it will be able to enjoy the fruits of redeploying the hundreds of billions of dollars excessively squandered on our Nation's health system, so that those resources can be used to benefit and strengthen all citizens in our economy in general.

Thank you.

Senator RIEGLE. Thank you very much.

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

Senator RIEGLE. There are some questions I want to ask, but I am going to hold off on those now.

Let me now turn to Mr. Joseph. Do you want to introduce the person that is accompanying you?

STATEMENT OF JEFFREY H. JOSEPH, VICE PRESIDENT, DOMESTIC POLICY, U.S. CHAMBER OF COMMERCE, WASHINGTON, DC, ACCOMPANIED BY KAREN BERG BRIGHAM, MANAGER OF HEALTH CARE POLICY

Mr. JOSEPH. Yes, Mr. Chairman. I am happy to be accompanied by Karen Berg Brigham, who is Manager of Health Care Policy for the Chamber. I thought she could be helpful in this session.

With your indulgence.

Senator RIEGLE. Please.

Mr. JOSEPH. I am happy to be here on behalf of the Chamber. Let me just say that this is the third decade that the Chamber has been working with the Congress on health care reform. When we started, employers were paying about $12 billion in annual health care premiums. It is up to about $145 billion now.

We work with a lot of coalitions on this issue and have over the years. The Chamber, in a sense is the ultimate business coalition, in that we have members from all around the country—big, medium, and small—including 2,700 State and local Chambers of Commerce. Most of the 180,000 corporate members of ours are

small business, many of whom have a very difficult time purchasing health insurance; many others who can get it have severe profitability problems because of the cost.

Let me just go to the heart of one of the key points I want to mention today, which I think follows up on Governor Castle's course. It deals with how to reduce the costs within the system.

I think we need to bring the entire health care system into the 21st century. Fundamental to this is exploring how new information technologies can be applied to save dollars by reducing paperwork and regulatory costs. Now I am not saying this because it is traditional in the Chamber of Commerce to talk about cutting back in paperwork and regulation.

But one of the secrets the public has come to learn from the war over the last couple of weeks is that high tech works. Governor Castle was talking about how costs in the education and health care systems continue to sky rocket out of control. These two systems comprise about 25 percent of GNP.

Very few high technology applications of information processing exists in those systems. Look, for example, at what a doctor is confronted with: this is HCFA Form 1500. Doctors have to fill this out about 3,000 times a year for reimbursement for Medicare, Medicaid, Black Lung and various third party payments. They fill out about 40 pounds of these forms each year, and they have been since someone invented the form.

Today, with technology, people can, with a little laptop notebook computer plugged into a phone, transmit the information in seconds to a data base, which can be used later for more important, more substantive analysis.

Now management information specialists I have been talking to indicate that implementing such technology might result in 5 percent in savings in terms of the whole health care system. That is about $30 billion. That is money that could be sucked out of the system and put into expanding access.

But the impact of information technology goes beyond administrative efficiency and to the heart of patient care. Studies by the Rand Corporation reveal that as much as one-quarter of hospital days, one-quarter of procedures, and two-fifths of medications may be unnecessary. Timely and secure access to information of the patient record is crucial to improving health care delivery.

Unfortunately, today most of the requisite clinical information remains imbedded in fragmented, paper-based, often illegible and sometimes irretrievable patient records. Many of the advances in information and communications technologies have not been adopted in patient records.

The establishment of a computerized medical record system could result in the more effective delivery of care to individuals while increasing the ability of providers and payers to monitor and improve the quality, appropriateness and efficiency of medical care.

Clinical data pooled in regional and national data bases and made available through networks would constitute a vast information resource upon which to base further health care policy, as well as clinical studies of effectiveness and appropriateness, equitable reimbursement policies and further scientific hypothesis for research.

The Chamber is pleased that the Institute of Medicine of the National Academy of Sciences is now preparing to release, in about 30 days I understand, a report concerning the essential nature of the computer-based patient record, with the hope that widespread use of this can ultimately introduce more science into the practice of medicine. We think this kind of effort needs and deserves support.

Technology also can impact other sides of the equation. We talk about defensive medicine. There may be $50 billion in the health care system spent on defensive medicine. I understand from talking to some doctors that there is a new software program called "Chart Checker" that is being used in some hospitals in Boston. Chart Checker double checks Emergency Room physicians' work to ensure that appropriate care was delivered.

I understand that malpractice insurers are now offering discounts to physicians who work in these hospitals. Again, that is money in the system that can be pulled out by intelligently bringing new technologies into play.

The Chamber also supports the development of practice guidelines, review protocols, and outcomes based assessments through a national effort led by physicians and scientists as the key to improving quality and eliminating ineffective care. We are pleased that this effort is now being spearheaded by the Agency for Health Care Policy and Research.

We think the scope of this work should be expanded beyond Medicare. And we think that the use of practice standards should be tied to protection for malpractice claims under State law. Again, another way to get a two-for-one.

Also, I want to raise one other issue quickly—substance abuse. One of the fastest growing sectors for health care cost containment deals with treatment related to drug use. Seventy-five percent of drug users work. They need their jobs. A lot of employers have told us they need to, and they want to, be screeners—finding who these people are and trying in their own best interest to straighten out the problem.

This is an issue that the Congress should focus on. We are working and supporting Senator Hatch's efforts to develop appropriate Federal certification of testing labs and a uniform Federal drug testing standard that will preempt adverse and often highly restrictive State requirements.

We believe these issues—independent of the nature of the health care debate—deserve increased congressional attention. If, independently, there is $50 billion savings in malpractice reform, and there is $30 billion in reduced paperwork, and there is $20 billion—as you suggested yourself, Mr. Chairman—in life style changes, you are talking about $200 billion a year. You are talking about a third of the system, more than enough money to solve everyone's problems. We should redirect the focus from shifting costs to one that revolves around reducing costs in a way that denies coverage to no one.

I would be pleased to take your questions and am pleased to be working with you.

Senator RIEGLE. Well, thank you.

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

Senator RIEGLE. There are two or three things I want to ask you both. I know, Mr. Miller, that Chrysler is out front in advocating the negotiation of provider fees. I know that sets off a lot of debate in different directions and so forth. Give me a sense as to what the corporation is doing in that area, and why, and where it seems to be leading?

Mr. MILLER. Well, (a) controlling the costs of the system, and (b) fairly spreading the costs among all the elements of our society.

Senator RIEGLE. Now if you take Chrysler as an illustration, so everybody understands this, you can produce cars or vans or trucks or some part of your product line, say, in or around Detroit. You could do it here in the United States. You could employ an American work force and provide the jobs, and provide the income to people who work, and provide money to State governments and local governments and so forth.

Or, as a company with manufacturing plants also in Canada, you could also in some instances move the production of a given vehicle across the Detroit River from the United States over into Canada and probably produce that very same car or truck in Windsor, Canada.

Now if you just take into account the health care costs that are attached to the work force building that car in America versus the health care costs that attach to the work force building the very same car a few miles away over in Windsor, in Canada, how much difference is there just in terms of the cost of the health care because you are producing it under the American system of health care and expense versus the Canadian system a few miles away?

Mr. MILLER. Our labor costs under our current contract are going to approach about $43 an hour by the end of this current contract. That is all costs wrapped up—wages, benefits, including health care. That is at least $10 an hour higher than the comparable costs in Canada and almost the entire difference between our U.S. wage cost and our Canadian wage cost is accounted for by the health care difference in the two systems.

I do not think it is entirely by accident, but it may be somewhat related, that at the time when we are shrinking our U.S. work force, our next major expansion in direct manufacturing employment will be in Canada in our Bramalea facility.

While I would not say that health care is the reason for this, it is certainly an incentive for all businesses operating on both sides of the border to put jobs in Canada in preference to putting jobs in the U.S. because of the tremendous and growing difference due to health care costs. So it is the lion's share of the $10 an hour difference.

Senator RIEGLE. Now if you take the number of worker hours that have to go into building a car, or building a truck or van, would that higher health care cost in the United States add, what, $1,000 more to the price of a vehicle; $500 more to the price of a vehicle?

Mr. MILLER. It would be on the order of $200 to $500 of differential, depending on the content of the car and how integrated you are as a manufacturer.

Senator RIEGLE. So everything else would be exactly the same? It would be the same car, the same features, everything else? It is

just a manufacturing cost because the extra health care costs in the United States would make that car $200 to $500 more expensive to make and sell than the very same car just produced across the border in Canada under their health care system?

Mr. MILLER. Yes. We are not talking about going to some Third World country to get $1 an hour labor. We are talking about putting jobs in a country that has high standards of living and education levels comparable to ours. That is Canada. And yet there is a huge difference in the cost of the work hour, strictly related to the way that the health care system is provided in our country and in theirs.

Senator RIEGLE. Now if those health care differentials continue—and I address this also more broadly to the Chamber of Commerce representation—in heavy manufacturing, particularly, where you have a high value-added product, so you have a lot of units of labor built in, you are going to have a higher health cost component in that particular product. It seems to me that if we are going to have these differentials where the health care costs per unit of production or output are much higher in the United States and lower somewhere else, we are going to find it very difficult to compete in international trade.

What is going to happen is, the jobs are either going to move overseas to another country where, say, more can be produced for less or we are going to find that we cannot sell our products. Our products are more expensive because they have more product cost in them than the products produced by a foreign country.

Is that not what we are facing here?

Mr. MILLER. Absolutely. You are right on. It is a big problem. I mentioned in my remarks that we have a big difference in the service sector of our economy and the manufacturing sector. And the manufacturing sector is carrying a disproportionate burden.

We will not be able to stand it. As health care has become a significant part of the total cost of a manufacturing business, we are seeing a declining manufacturing sector in this country. I think a big contributing factor to the decline of our manufacturing sector is our world noncompetitive situation on taking care of the costs of health care.

Senator RIEGLE. Let me ask you, Mr. Joseph, you represent companies of all sizes across the United States, is this health care cost premium that comes by virtue of the nature of our system, versus the way the rest of the world is doing it, is that cost factor on the margin hurting more and more American business as you see it?

Mr. JOSEPH. Oh, absolutely. We hear from businesses of all sizes, from the largest to the smallest, that something has to give. There has been a tendency over the last 20 years to try and figure out how some deep pocket could pick up the tab, and often business was looked at as that deep pocket. The people are starting to discover that business is nothing more than the aggregation of the people who work there and their ability to pay for them.

And the weak economic condition in this country right now does not favor adding additional costs to employers of any size, let alone forcing currently uninsured small businesses into a system where the costs are completely out of control.

To relate back to the last question in terms of the work force here versus abroad, it is not just the health system that is a major uncompetitive factor, but also the quality of the work force in terms of their education and skills.

As I said before about education and health and relating back to Governor Castle's comments, we have two systems where we have just thrown billions of dollars at the problem. We said in 1982 we had a nation at risk and we put a trillion dollars into our public education system—and national test scores have gone down.

Essentially, the education and health systems operate as they did 100 years ago. We really need to get the systems with it and get technology throughout the whole process and look for efficiencies and look for savings and better ways to do things.

Senator RIEGLE. Let me ask you this, Mr. Joseph, I take it, then, if you are getting feedback from companies across the United States, that there is this rising profile of health care costs, partly for the inefficiencies and the way the system is engineered. It is making more and more of them less competitive on an international basis and, therefore, it has to be costing us jobs.

Mr. JOSEPH. Absolutely.

Senator RIEGLE. So we are losing jobs in this country because we have a cost component there that is really out of control, versus facing off against the products from the rest of the world. Is that a fair summary?

Mr. JOSEPH. Absolutely.

Senator RIEGLE. Well, that, it seems to me also, together with the Chrysler story, provides a very powerful argument for why we should not wait any longer. I mean we have a trade deficit that is running about $100 billion a year. We are adding international debt at the rate of about $1 billion every 3 days.

We are going to owe the rest of the world $1 trillion net from all of the accumulation of trade deficits in the last few years, and we are losing jobs at the same time. I think that is a terrible track to be on in terms of the trend lines.

I am also hearing more and more from employers in Michigan of all sizes that in almost every case they are cutting back on health care coverage. They are either having to squeeze it down, bargain for higher co-payments, or go to contractual care arrangements to try to get the cost down that way.

I have talked with any number of businesses in Michigan, and some who are Chamber of Commerce members, who have discontinued health care insurance altogether in the last year, who had a health insurance plan in place for employees and then took steps for a reduced number of key employees, even including the owner of the business. I just had a fellow the other day tell me that they finally have had to eliminate all health insurance, even for himself as the owner of the business, and he has quite a large number of employees. But he has found the cost of health insurance to be prohibitive of the cost element on the margin.

So you have more and more people who are taking their chances, in a sense, with whatever private insurance they can get. A lot of people cannot get private insurance. I mean you cannot get it, even if you can afford to pay for it. A lot of people cannot afford to pay for it outside of an employer plan or an employee plan. If they go

out and try to contract as a unit of one, either they are turned down for some reason or, if they are not turned down, they say, "Yes, it is going to cost you $400 a month." And somebody says, "Well, I do not have $400 a month." Well, then, sorry, you know, we are not going to provide the private coverage for you."

So where on the list of priorities of business, generally, does this health care crisis or cost problem come today across the country? Mr. Miller, in terms of the large manufacturers, would this be right up at the top of the list, not just for Chrysler, but others that you talk with?

Mr. MILLER. Well, as you know, it is right up at the top of our list. I said it is approaching $1 billion a year of cost for my corporation, which is far more than the profits of my corporation these days. It is the single element of cost in our business which has a full committee of our board of directors devoted exclusively to this issue. That is how important it is.

We have Owen Beaber and Lee Iaccoca, and several others of us, who meet as a committee on this subject. And there is no other line item in our whole budget that gets that kind of board-level attention. So it is a top priority item to us.

Senator RIEGLE. So it is an urgent issue?

Mr. MILLER. Absolutely, sir.

Senator RIEGLE. And it threatens even the survival of the company over a period of time?

Mr. MILLER. It is a liability of my company.

Senator RIEGLE. All right.

Now, Mr. Joseph, what would be a comparable bottom line out of the business community? I mean, how big and threatening a problem is this for the business community, generally, across America today?

Mr. JOSEPH. I would answer similarly. It is right at the top. It might be one, two or three, depending on which business person you talk to. You do not have to be a multi-billion-dollar company and pay a billion dollars to be threatened. There are a lot of small business people who are also paying more in health care coverage than they are earning, being forced to discontinue plans.

There are a lot of disincentives in the system, as you know, to the smaller people being covered. You do not have the same tax deductibility for self-employed and unincorporated forms. Of course, every time a Section 89 comes along or COBRA expansion, you create further complexities out there for medium-sized businesses to figure out how to wade their way through that morass.

So the system itself is not geared to be easily accommodated by those trying to work with it. There are so many things we do wrong in delivering this system that I think if we try to figure out systematically how to right the wrongs and make the system work more efficiently and effectively, we will free up dollars and bring more people into the system.

Senator RIEGLE. I take it, said another way, that the business community across the country does see this problem now. This problem has gone on so long and has become so acute that it really is an urgent matter for American business; is that correct?

Mr. MILLER. Oh, absolutely. I think it is fair to say it is in a crisis stage.

Senator RIEGLE. Now what is significant is that we do not often get labor and management agreeing on an issue. I mean occasionally that happens. Just as often or more often there are differences of opinion. But we have just had a policy statement come out of organized labor—of course, that is just part of the jobs in the country, but a significant number of those jobs—where they have, in effect, said the same thing. Now their vantage point is somewhat different.

The point they are making is they see the health care crisis through their window of experience as a crisis problem of an extraordinary nature that has to be dealt with. I say that because in addition to that, as we are going to hear from the next panel, virtually every part of interest that I talked to—the hospitals are coming in, the doctors, the health providers, the insurance companies, the States, the uninsured people, the insured people, are all saying the same thing.

That usually does not happen. But they are all saying the same thing—namely, that the system is in crisis, that costs are going through the roof and we cannot continue to afford what is happening. You have a whole lot of people who do not get any coverage whatsoever—the walking wounded out there in our society—and that problem needs to be addressed.

So it seems to me that we now at least have a consensus or viewpoint of all of the major parties of interest that this problem will not wait any longer. It is time to do something about it and to take it apart and reengineer it, and to get the efficiencies and the coverage.

There are going to have to be certain limitations to work those out as well, to deal with the insurance issue in terms of the cost for practitioners in medicine and so forth, and to come up with a rationalized system that meets our health need and still keeps us in the ball game in terms of an economic system that is viable in this new work economy.

As we end up without enough jobs and enough national income, you know, we can talk about a lot of things, but we are not going to have the money to do much of anything. Whether it is fight foreign wars, or provide more for education, or house people better or send kids to college or what have you, we have to have the national income off a good, strong economic system and job base to pay for that.

So, you know, this is dangerous to our health in more ways than one. I mean it is dangerous to our health in the first sense, but it is also dangerous to the economic health and future of the country. That threatens everybody, even the person today who is well insured, and who may feel he or she has plenty of money to go to the best doctors. If the whole health care system is out of whack enough that our system is put in jeopardy, even the person who can get health care is endangered in a different way.

It seems to me that is part of the message that has to come out of this hearing today—you know, the fact that we have been working on this for three decades, as some have testified here today. We have been circling this problem, and circling this problem, and circling this problem, but we have not been able to do much in a substantive way about a major overhaul.

I think the time has come to do that. I think the President is going to have to become convinced of that as well, I might say. I think the administration is going to need to articulate more forcefully its domestic agenda, as opposed to its foreign policy agenda.

It would be my hope that President Bush might decide to tackle this health care issue head on, because we have to have the administration involved in this along with the bipartisan leadership of the Congress if we are going to crack it open.

But it sounds to me like you are all saying that you are ready to work with us to do it and that we cannot wait any longer. That is what I am hearing from the business community. Is that a fair conclusion for me to reach?

Mr. MILLER. Well said. Yes, sir.

Mr. JOSEPH. And we agree with everything you have said.

Senator RIEGLE. Very good.

Thank you very much for your testimony. Let me excuse you now and call our final panel.

This panel consists of Dr. Robert Graham, who is the Executive Vice President of the American Academy of Family Physicians; and Mr. Colin Rorrie, Jr., who is a Ph.D., Executive Director of the American College of Emergency Physicians from Dallas, Texas, testifying on behalf of the Physicians Organizations for Access to Care Coalition. They are being joined at the witness table by Mr. Stuart M. Butler, a Ph.D., Director, Domestic and Economic Policy Studies of the Heritage Foundation here in Washington; and then finally by Mr. Carl J. Schramm, President, Health Insurance Association of America, also based here in Washington.

Gentlemen, we are pleased to have you here today.

I want to say at the outset to Dr. Graham and also to your colleague, Mr. Rorrie, who is with you, that we very much appreciate the letter that has been sent to us. I appreciate the initiative that was taken on a letter dated January 16, 1990—I know you will address this in your remarks—enlisting the public support of a very large number of medical organizations of different kinds.

I am just going to read a few of them off here: The American Academy of Family Physicians; The American Academy of Neurology, Opthamology; The American Academy of Orthopedic Surgeons; The American Medical Association; The American Society of Internal Medicine, and many others. I do not mean to leave anybody out. We will put it in the record.

This is on behalf of a very strong call for fundamental changes to be undertaken in this health care system, and I appreciate that leadership.

[The letter appears in the appendix.]

Senator RIEGLE. So let me start, Dr. Graham, with you today.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS, KANSAS CITY, MO, ACCOMPANIED BY COLIN C. RORRIE, JR., PH.D., EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, DALLAS, TX

Dr. GRAHAM. Thank you, Mr. Chairman. We appreciate very much having the opportunity to appear before you and provide re-

marks on behalf of the Physicians Access Coalition. I am accompanied by Dr. Colin Rorrie, who is the Executive Director of the American College of Emergency Physicians, who is one of the Coalition members also.

Since you do have the full text of our statement before you, I would simply like to summarize what we believe are some of the more important elements of the issues facing the committee and some of the choices and decisions that we think are going to need to be made over the next several months.

I think it is significant for some of the reasons that you have already touched on in your exchange with previous witnesses that we are at a time when many in the country perceive that the system of health care delivery, and the cost of health care delivery are reaching a crisis stage.

Although we pride ourselves on having probably the best quality of health care to be delivered, we must acknowledge that that quality of care is not universally available or accessible to our citizens.

That is one of the reasons why a year ago, with the letter that you referred to, a Coalition of health professional organizations, ranging in scope from the largest national organization of physicians, The American Medical Association, through specialty organizations, such as mine and Dr. Rorrie's organizations, decided to come together to see if we could work conjointly within the medical profession and with the Congress to determine a set of principals which could guide the development of legislation which could address these pressing issues.

The principals that we would place before you, we believe serve as guideposts of development of legislative change. Each of us, as independent organizations, have our own legislative initiatives. But we believe these principals are ones which have sufficient common ground that we can work together, and with the Congress, and with the other interest groups, to bring about change in a tangible and timely fashion.

Let me summarize those principals for you, because they may touch on some of the points that you would like to pursue later. Number one, we believe that the current system of health insurance in the United States, which is largely employer-based, has worked well historically and is working well for those individuals who are fortunate enough to have it provided as a condition or term of their employment.

We believe that the traditional base of health insurance should be the basis on which further enfranchisement is based. We recognize that there may be some changes that need to be looked at as we try to broaden that base. We need to look at the elements of cost sharing. We need to look at phasing in changes that may be necessary. We may need to look at some types of reform within the insurance mechanism itself.

But we would propose as principal number one that you start with something that is working well in our system at the prevent time and try to find ways to bring more people into the enfranchisement.

Secondly, we recognize that the Medicaid program has similarly met many of the objectives that were set out for it some 20, 25 years ago. We believe that the Medicaid program, if reformed and

expanded, can continue to play an important role in providing access to services for public beneficiaries.

Third, we believe that no matter how successful the expansion of employer-based health insurance or the Medicaid program, or the combination of that, there will still be individuals who, because of their individual circumstances, personal circumstances, may well not qualify for coverage under either one of those; and, therefore, is the third principal.

We recognize that either on a State or regional pool basis some types of risk pools are going to need to be set up so that individuals will be guaranteed access to coverage for health insurance, again on a cost share basis, reflecting their own personal circumstances.

Then there is the fourth principal. We believe that these health insurance programs need to emphasize basic medical services that are most commonly needed by the vast majority of individual patients. It may not be possible, nor desirable to try to cover in a specific insurance plan everything that might be done for everyone at every time.

We have adopted these principals for a specific reason, that we believe it provides a strategy which is doable. We recognize there are other approaches to the issue, and other approaches have been and will be proposed and may be discussed here this morning.

But by basing this initiative on the current experience of employer-based health insurance, we believe that we have an initiative which legislatively is doable and is open to incremental changes, that a choice does not face the Congress of a major redo of a system, which would be of substantial concern to a number of individuals, providers and patients alike, but that it is possible to bring increasingly more people into coverage, and adequate coverage, day-by-day, year-by-year if that be the case, rather than trying to do something that is a substantial revision of the entire system.

We also believe that this provides an equitable basis for providing health insurance.

Let me close by saying that we appreciate on behalf of the Coalition very much the interest and the initiative which has been taken by the members of the bipartisan work group and yourself. We think that this is a timely issue, and an issue where there is building concern on the part of the public and the providers that basic and critical issues have to be addressed.

Our hope is that through our efforts, through your efforts, of those in the Congress and administration, that we will be able to seize the initiative of the interest and the concern and as necessary take the heat.

Senator RIEGLE. Well, I appreciate that very much. I appreciate the leadership that you and your colleagues are giving. The way that we take and finally wrestle one of these big problems to the earth and fix it is that we have got to get all of the critical parties of interest working together.

Very often when we have a major policy issue we have groups that are colliding-head on and are so set in opposing positions that it makes it very difficult sometimes to actually get into the problem and to solve it.

What I am sensing here is that every major party of interest is saying that something has to be done. Now there are differences

and points of view, and we are going to have to cut and fit as we go here. But I think it is significant that this large number of medical organizations has now gone on the dotted line to say that we cannot wait any longer to get a mixture of changes worked out here that meet these objectives.

I have asked the staff to get a copy of that letter, which is dated January 16, out to the members of the press who are here. I find this very significant. I think to have the people in the medical profession that actually are out there providing health care services to individuals reach a level of concern and commitment to come forward and call for this kind of change, and recognizing there are going to be trade offs.

There are going to be some things in the package you will like and some things you will not like. But on balance we will all be better off under some kind of a system that gives everybody access to the system and brings these exploding trends in terms of cost and administrative burden under some kind of reasonable control.

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

Senator RIEGLE. Let me now go to you, Dr. Butler. We would be pleased to hear from you at this time.

Let me just ask, was Mr. Rorrie going to make any comment?

Dr. GRAHAM. No.

Senator RIEGLE. Very good.

Dr. RORRIE. We will respond to questions, sir.

Senator RIEGLE. Very good. Thank you very much.

Dr. Butler?

STATEMENT OF STUART M. BUTLER, PH.D., DIRECTOR, DOMESTIC AND ECONOMIC POLICY STUDIES, HERITAGE FOUNDATION, WASHINGTON, DC

Dr. BUTLER. Thank you very much, Mr. Chairman. Let me emphasize that I share the belief of the other people who have been testifying before you this morning that we must achieve affordable access to quality health care for all Americans, but we cannot do this without fundamental reform of the health care system.

It seems to me that that reform must consist of two elements. One is reform to improve the efficiency and supply of affordable care, and proposals to tackle the malpractice problem, to inject greater competition into insurance, and to better measure the quality of care are examples of this element.

Similarly, what is happening in States such as Oregon and elsewhere are important in terms of experimenting with ideas. But I believe we must also reform the demand side of the health care equation. In particular, Congress needs to reform the tax treatment of health care spending.

Today, the only way the vast majority of Americans can obtain tax help to buy health care is through the tax exclusion for company-based plans. Unfortunately, that break which now costs the Treasury about $50 billion each year has serious side effects. For one thing it is grossly inequitable, giving the largest tax break to the most affluent, yet little or no help to millions of low income families who must buy care or insurance themselves.

Indeed, most of the uninsured are actually taxed to subsidize expensive plans for senior executives and other affluent individuals. And also by helping to create the illusion of free company-paid benefits, the current tax treatment discourages consumer scrutiny of medical costs and so fans medical price inflation.

I contend, Mr. Chairman, that until we correct the gross inequities and the perverse incentives in the current tax treatment of health care expenditures we cannot solve the problem of uninsured families except with rapid inflation and at a staggering cost.

At the Heritage Foundation we have developed a health care proposal based on tax reform. In a nutshell, our proposal consists of two parts. In part one we would phase out the tax exclusion for company-based plans, making the value of all such plans count of taxable income to the employee. We would use the revenue from this to create a new credit in the personal tax code.

This would be a refundable, above the line credit, for family expenditures on health insurance, prepaid plans or directly on health services. The percentage credit would be based on the family's total health spending, compared with its income. The higher that ratio, the higher the percentage credit.

In the second part, the Federal Government would legally require all heads of household to purchase a health plan containing catastrophic coverage and perhaps other services. If the family could not discharge that obligation at reasonable cost, despite the refundable credit I mentioned, it would be granted access to Medicaid or a subsidized State-sponsored insurance pool.

This two-pronged reform would restructure existing government help to create a truly national health care system in a budget neutral way. Most government help would go to those who need it most under our proposal. That help would not be contingent upon the generosity or otherwise of each employer.

Moreover, if a worker switched jobs, there would be no interruption whatsoever in health coverage. With families buying plans themselves, with help through the credit, consumers would be far more sensitive to the costs and benefits of alternative medical plans, spurring much greater competition in the health industry.

I should note that while individuals would be quite free to choose their own package, we envision that most Americans would in practice join a group to act on their behalf in choosing a packaging of services. These groups might be formed by unions, a church or, of course, by employers, as today.

The key point about our proposal, however, is that a family would not have to enroll in an employer organized plan to obtain tax relief for a medical plan. Another key point in the proposal is that it would cross subsidize the sick and the poor through the tax system, not as today, by trying to eliminate risk assessment from setting premiums for individual families, which is at the heart of today's adverse selection problem.

Under the Heritage proposal, premiums would more accurately reflect risk, but the sliding scale credit would enable families to afford appropriate premiums.

Mr. Chairman, I believe tax reform must be a crucial element of any comprehensive health care legislation. As a first step to tax reform as a key segment of that, Congress should consider a cap on

the tax exclusion for company-based plans, in order to finance an expansion of the refundable tax credit for certain health care insurance contained in last year's child care bill.

Moving in that direction, I believe, would provide new incentives and financial help that would reinforce other reforms designed to improve the supply of medical care.

Thank you, Mr. Chairman.

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

Senator RIEGLE. Let me just ask you one question, sort of following the logic of the idea that you spoke about. That is, if you go through the Tax Code and a tax credit approach, it looks to me like you are going to have time lags, just leaving all the other questions aside.

In other words, you have health care need now. You have to go get your health care service. You have to pay for it presumably. And then in effect, down the line, later on when you file for your taxes I assume you would get some credit for that.

So, in effect, you would get an offset. How do you deal with the question in real time of being able to, you know, get people to the health care they need and to pay for it, you know, on a timely basis? How do you overcome that?

Dr. BUTLER. For most workers, Mr. Chairman, that would be folded into the normal withholding in their regular pay check. They would simply do the same thing as they do when, let's say, they buy a house and want the tax deduction for the mortgage interest. Normally they would go to their pay department and change their withholdings to reflect what they anticipate to receive at the end of the year.

We would see exactly the same process in this credit. It would be folded into the normal withholding structure. If it was refundable, it would, in effect, be a subsidy paid as a payroll supplement to those individuals.

We also imagine that to improve the practical operation of our proposal larger employees might well be required to deduct from the payment to each employee, at the request of the employee, an amount of money to pay for the coverage that they wish, and send it directly to the insurer or the health plan.

So we think, in fact, in operation this issue of a time lag really would not arise at all. For those who are not employed, then there could be requirements that either providers delay insistence on payment until the end of the year or that the government itself could provide the eligible credit directly to providers.

So we think that ways can quite easily be found to avoid that time lag problem.

Senator RIEGLE. Let me just ask you one other thing relative to that before we go to our next witness. That is, if I heard you right, there was going to be a sliding scale. There is a family, for example, with an extraordinary amount of medical bills relative to their income, and I do not mean a catastrophic illness, but obviously a large family with several children, is probably going to have more health costs, would the percentage of the tax credit be larger?

Dr. BUTLER. Correct.

Senator RIEGLE. In other words, you would build in a way of kind of a social equity or balancing out of that. But even in that case,

would you not still have the problem of a time lag? In other words, let us say in engineering a system like that, if somebody is going to have a profile of health care expense, how do you ever anticipate it properly or how do you respond in any kind of a real time basis when you are feeding money out for health care costs versus accruing and getting your hands on a tax credit that is designed to somehow keep you afloat in terms of the rest of your financial circumstances?

Dr. BUTLER. Well there are two subcomponents of that general issue. One is that in a case of a family with, say, a poor medical history or a very large family, one would anticipate throughout the year a relatively high level of premium costs or out-of-pocket expenditure. That would be folded, as I mentioned, into the credit that you would obtain through the withholding system.

Second would be a case of a family, or even an individual, facing a very unusual situation suddenly. Now as I mentioned, our proposal does insist that all heads of household obtain catastrophic coverage. So, in fact, the number of cases of a very unusual large amount not covered in any way would be very small in our opinion.

But even in that case it seems to me that it is not a particularly serious problem. Today, of course, families in deep trouble because of medical bills do not get any help. At least they would get a credit under our proposal; and I think our proposal would at least assure the providers of services—since the patient is eligible for a credit—that they will eventually get paid; and therefore, some requirement on providers to hold off insisting on payment until that credit comes through would seem to me to be a reasonable requirement.

Senator RIEGLE. Let me just ask you this, Dr. Butler, how urgent is the current problem whether that scheme or another scheme is used, has time run out for us in terms of the way the system is now put together and the cost burdens and so forth?

How urgent is this problem?

Dr. BUTLER. I share the believe of, almost everybody who has been before you, that the system has chronic problems. Like most chronic problems, it requires decisive long-term correction. So simply just adding on, for example, modest additional programs for the existing system to help one or two groups of people does not get at the underlying problem of massive cost inflation and huge gaps in the system.

Now on how we address that, I will probably disagree with some other people before you. But I think we all agree that a fundamental reform of the system is required.

I just believe that in addition to some of the things, such as malpractice reform and State flexibility, that have been mentioned, we also have to get to grips with the system of perverse incentives within the current system, and also the gross inequities in the way in which we try to help people through the Tax Code.

Unless you do both of those you are not going to get a successful reform.

Mr. Schramm, last but by no means least, we would like to hear from you now.

STATEMENT OF CARL J. SCHRAMM, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. SCHRAMM. Thank you, Mr. Chairman. Before I begin my informal remarks, I would like to thank you personally and for the leadership of the Finance Committee last fall in the expansion of the Medicaid program to children and low-income families. As you may know HIAA hosted and formed the coalition of almost 20 private sector organizations that supported and lobbied for that expansion. Once again we all thank you.

I have come to talk to you about two things today that are fundamental reforms in the insurance industry. I think they bear particular attention. The first relates to the business of small group insurance and how small group insurance operates and will operate in the future. The second relates to health care cost inflation and the steps taken in the private industry.

What I have come to describe, I believe, could be accurately and honestly characterized as profound reform in this industry on both frontiers. Last Wednesday after working on this issue for over 3 years, the Health Insurance Association of America Board finalized recommendations for massive and significant regulatory change in the small group market place.

Specifically, I would suggest to you that this reform would promise the market place that no employer with fewer than 25 employees who sought health insurance would be denied access to the market. We will guarantee any small business that there will be a carrier ready to take his business in the future.

Once insured neither the group or individuals will be denied continued coverage because of the deterioration of their health status or the deterioration of the status of the group.

The third precept is, there would be a limit placed on the rate of year-to-year premium increases in these groups relative to other groups insured by the same carrier.

Fourth, no group would pay more than 50 percent more of the average cost of similar groups for this basic coverage. Thus, we would promise great regulation of small groups both in the initial year and in subsequent years.

Fifth, coverage could not be denied nor new preexisting condition restrictions applied to any individual changing jobs or changing group carriers.

Senator RIEGLE. I must say I am particularly happy to hear that. I keep running into people who, have developed serious health problems that do not feel they can move because if they lose their coverage, they are not going to come back under an insurance umbrella so they are scared to death. So they are sick and pinned in place.

Mr. SCHRAMM. That is right.

Senator RIEGLE. This is not good for them and not good for the country. So I appreciate hearing something constructive in that area.

Mr. SCHRAMM. The sixth precept would call for a privately funded and administered reinsurance mechanism or a pool which would be established so that insurers could reinsure high risk premium individuals.

And seventh, and finally, medical underwriting would be allowed only for the purposes of determining the risk, to assist in the decision of the carrier to reinsure any individual or group. But medical underwriting would not be used to restrict access of individuals or groups to the insurance market.

Now as I said, these are significant and profound reforms that our Association and our industry is proposing, both to the NAIC and to the State legislatures. We believe these reforms are necessary because of some of the practices that have grown into the insurance market that you have just cited, Mr. Chairman.

But in turn, the practices observed in the last few years in the insurance market are derivative with the second issue on which I wanted to speak today—that is cost inflation. You properly pointed out that there are 31-37 million people who are uninsured. I think it is important to appreciate that over the course of the 1980s, the number of people who are uninsured approached 800,000 to a million new uninsured persons a year.

Despite the fact that our 300 member companies on the commercial insurance side and the 76 Blue Cross plans each insure in excess of a million new people every year, the net increase is only 2 million people insured every year where it should be 3 million people. That is the problem.

Now that problem, as I suggested, is 100 percent derivative. The high cost of health insurance relates 100 percent to the high cost of medicine. If over the last decade we had seen growth in the CPI for medical services at 6 percent, the cost of health insurance would have gone up roughly 6 percent, you would not be holding these hearings.

The fact is that in the last 3 years the rate of inflation has, in fact, started to escalate once again; and while we have seen comparative stability in the rate of GNP going to health insurance, the Department of Commerce now reports that we have gone from roughly 11.1 percent 2 years ago to now 12.3 percent of GNP dedicated to health over the last 2 years.

As I would suggest to you, this is an increase in the rate of change that is not precedented in the past. The problem is revisiting us with great ferocity.

The second issue which represents profound reform in our industry is the development of managed care. Under managed care, private insurers are now taking the responsibility for containing the growth of health care costs through our customers. We estimate that somewhere between 25 and 30 percent of all private commercial business is under a managed care regimen; and that the rate of change to the customers will be significant, in some cases 2, 3, 4, and 6—in some cases even more—percent difference in the rate of premium growth under the managed care program versus other types of insurance plans.

We did not embark on managed care as a voluntary effort necessarily. We see ourselves playing a default role here. Our customers complaints have been so high that insurance companies are now playing a new, altogether untried role, of disciplining the provider system on behalf of our customers.

I would suggest to you that these two steps represent profound change and a commitment in the private commercial insurance

market, our half of the dual system of public and private financing to make real progress in reform of the system.

If I may anticipate a question you would put to me, as you have put it to so many other witnesses this morning, it is easy to see that everybody calls for change, as the previous witnesses have. Everyone is committed to change. But if someone who converses on the subject daily, and one who represents the commercial insurance side of this problem, I would suggest to you that while we will see big business and labor, and hospitals and physicians come to you and talk about the need for change, one party alone has come forward today and said to you after hard work and great home work, we can commit ourselves to regulation and regulatory change that will make the shoe that we wear pinch.

I believe that the other parties to this debate must come forward and appreciate a future where there will not be unbounded growth and a call for government to take up the slack in the system that will meet their income needs, or their revenue needs or their capitalization needs.

This is the type of agreement and debate that we must commit ourselves to as a country. I thank you, sir, for convening this meeting of the subcommittee of the Finance Committee to start on this road.

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

Senator RIEGLE. Well, thank you very much. Let me just ask you, Dr. Schramm, a question that I have put to the others today, and you touch on it at your final comment. In terms of the difficulties that we are seeing out there in the health care system and the range of problems we have talked about today, I take it that the recommendation your group has just developed is an acknowledgement of the fact that we really do need to move on an urgent basis to make some changes in the health care delivery system, and access to health care.

I assume that you would agree with what others have said in that area?

Mr. SCHRAMM. Absolutely, Senator. That is an absolutely fair and accurate representation of a very sophisticated and informed debate in the insurance market.

Senator RIEGLE. I am going to look very carefully at what you have developed in the way of the recommendations and the adjustments that you have just described.

Dr. Graham, let me ask you this: I know your organization supports an employer-based system that would mandate employer coverage for their employees. Rather than a mandate, would you also support use of tax incentives and disincentives to encourage employers to provide care?

Dr. GRAHAM. Let me respond to that as an individual member of the Coalition.

Senator RIEGLE. All right.

Dr. GRAHAM. Because that is not a topic that all 18 organizations have sat around the table and discussed.

As an individual I would say that we would investigate with interest any set of mechanisms which would provide better coverage for more individuals. If those mechanisms involve changing tax

policy in such a way that new revenues are generated and there is a better focus on mandated core basic health benefits, those could be two very attractive elements of changing tax policy.

Now having said that, I still must remind you of my disclaimer. That is, I would not want to leave you with an impression that this was going to be part of any proposal that we would put forth. But as you look at the issues that we have tried to articulate so far in terms of four principles, those principles can be accomplished in a multiplicity of different administration and financing mechanisms. Which specific set of mechanisms we would decide that we would support I think requires a very careful look at cost and benefits.

But nothing I have heard Dr. Butler outline would to me seem to be something that could not be discussed.

Senator RIEGLE. Now I know your organization is developing recommendations for improving cost effectiveness of the delivery of medical services. I am wondering—I do not know how much you have spoken as a group around the table about this—but I am wondering what cost containment elements, you personally or if you can speak for the group, think should be included in a health care reform proposal.

Dr. GRAHAM. Let me give some comments about that, and then let me also give Dr. Rorrie an opportunity to comment. Because I think this is an area where a couple of perspectives may be useful.

We recognize that the major agenda facing the players this year or this Congress is now the cost element. The agenda last Congress may well have been, are we serious; can we really look at it an array of programs and an array of changes. Now to be serious you have to be able to come forward and say, how are we going to deal not only with access and with cost.

The Coalition has before its members now, literally, some 16 or 17 different elements that could contribute to different ways of cost containment. We are still in the midst of our deliberations in terms of which of those elements we would wish to turn into a fifth or sixth principal.

What I think has to be clear to all of us, though, whether we are providers or patients or legislators is, there are only three basic avenues that one can come at cost containment. One is the definition of services provided. The second is the number of units of a service that will be provided. And the third is the cost per unit.

Now I think we tend to look at cost containment as being a provider side issue, which certainly it has implications for physicians and hospitals—to some extent, even insurance companies. But any decision that is made as a matter of public policy to effectively constrain cost will be very heavily a patient side issue also.

I think that may well not be appreciated as in this early part of our debate. Because there is no way that we can constrain costs without doing one of those three things. And as you do one of those three things, you start saying something which we have not said before; and that is, "Yes it is possible, but it will not be provided."

Senator RIEGLE. Dr. Rorrie?

Dr. RORRIE. I think from our particular perspective, emergency physicians and looking at the environment there, we would concur with what Dr. Graham has said. I think one area that we are particularly concerned about, and we have heard about it this morn-

ing, is the whole question of mandates. We are mandated by a piece of Federal legislation that requires any patient who comes through the Emergency Department to be provided a screening examination.

We had been providing that type of medical care to any patient coming to the Emergency Department. But now through Federal mandates there are significant penalties associated with that particular initiative, relative to movement of patients between institutions in terms of an institution's ability to provide the level of medical care that is necessary.

So I think in any cost containment initiative we need to be also careful about the mandates that we live under. You have placed us under very severe mandates from a Federal statute standpoint that not only applies to Medicare and Medicaid patients, it applies to any private care patient coming through the system.

So I think we need to take a look at that in relation to any of the schemes that Dr. Graham has pointed out today.

Senator RIEGLE. Let me ask both of you: Looking at these rates of inflation, and the pattern of cost increases for medical services, help us understand why the rates of increase are higher there than they are in so many other areas of the economy. I mean we get inflationary pressures everywhere. But why the persistence of such a high rate year after year? You fellows are out there practicing medicine. What is imbedded in it that creates that profile?

Dr. GRAHAM. A clear and precise answer to that question probably is a Nobel prize type of answer. Look at our system from a very simple-minded point of view and compare it to Canada, to Germany, to Great Britain, some of the other organized systems. We do more to more people more frequently at greater cost than those other systems.

There is no question in my mind that one of the things that fuels that is that we spend $8 billion a year on government-sponsored R&D called "medical research". I think every one of us probably supports the outcomes of research and believes that that is a social good, but we may not take into account what the implications are in a delivery system. Once we have demonstrated that something can be done, we have a system which has no constraints, either through the insurance side or in the investment side, that says that will not be covered.

It is those issues of constraints that you can demonstrate in a Canadian system, a British system, or a West German system that we just do not have here. Those are the basic choices that I think will be facing us. What system of constraints—whether it is on providers, on patients, payors, or insurance companies—will be acceptable to us? If we are not willing to make choices about those systems of constraints, we will continue to look at that double-digit inflation and we will not have solved our problems.

Senator RIEGLE. I have a simple mind in this area, too. And you have to make these things simple, first, to understand them and then work back through the complexities. You know, we have had, in this Persian Gulf war, this situation where you have had technologies matched against problems.

You have had, for example, the Iraqis who can launch these Scud missiles towards Saudi Arabia and toward Israel, and the United

States having developed a Patriot missile, which is more sophisticated, that in a matter of just two or three minutes can pick these things up and go up and intercept them.

And you can almost think about that as a medical problem. You could almost think of some kind of a sickness or disease in the way of a Scud missile coming at somebody. And if you can come up with enough medical technology on the other side to try to intercept that or to deal with that problem—maybe a very sophisticated medicine or a very sophisticated treatment program to deal with some kind of an exotic cancer—if you invest enough money in a medical Patriot system, you are in a position to head off or deal with some kind of a threat to a person's health.

Because of this—I think you said—$8 billion we are spending a year on medical research of various exotic kinds, we are coming up with ever more sophisticated ways to kind of cut off at the pass these very difficult and exotic health problems that you might think of as Scud missiles in another form.

But what is the implication of that? Do I draw from that that, in a sense, if we are building into the inflation of costs ever more exotic kinds of research and technology to get at these problems, it is just going to continue to cost us more and more? I mean how do I make sense out of that? How do I reduce it to something that the American people and all of the people around here can understand?

Dr. GRAHAM. If I could try one follow-up on that. I do not wish to leave the impression in your mind that the answer to the problem is research. I simply use that as an example of an element in a very complex relationship I think we do not look at very often.

There is a very interesting book that I have seen recently. It may be more familiar to members of the panel—I cannot remember the author's name right now; I will make that available to you as a matter of the record—which examines the cultures and cultural expectations of medical care in several industrialized societies.

What becomes very clear is that the expectations of medical care among Canadian citizens are very different than expectations of care among American citizens. That is one of the issues that I think we have to deal with. We do have a society which is a "can do" society, that has served us enormously well in the military field and others.

But in that can do society because of the peculiarities of the way that we have financed an organized medical care, there is the assumption on most people that if there is a technical, complicated, serious medical problem, there is somebody out there that can probably do something about it.

The good news in the American system is they are right. The bad news is what we are here talking about this morning. And that is, when you get into the third transplant it is enormously expensive. We have the capacity to do the transplant. We now are questioning whether or not we have the resources to pay for it.

And if we ever come to the conclusion that resources are an issue, then I suspect we have a major issue with the American public because we, whether we are providers or Congressmen, will be trying to communicate a different level of expectations than we have developed over the last 30 or 40 years. And that is what I

think will be the crux of the public debate when any plan comes out.

Whatever plan you have heard about this morning, or will hear about, if it is going to address these issues, will force very difficult choices. It is tempting to look at providers and say those choices are really going to impact on you. Anything that impacts on the providers impacts on the patients.

When you do something that gives better coverage to 15 percent of the people, you may be taking coverage away from 80 percent of the people. You count votes better than I do. You know what the impact of that is going to be. That is where it will test our collective will to see whether or not we can come up with a better, more equitably structured system.

Senator RIEGLE. I was talking the other day with the man who is the executive director, a doctor who runs the cancer research facility at the University of Michigan, which is a very advanced and sophisticated place. They are operating out on the horizon of a whole series of cancer-type problems and how you intercept these problems and solve them, and how you try to cure people or extend their lives.

We are talking about leukemia, and the fact that in the instance of leukemia now there is this interferon treatment that has been developed. I did not ask the cost, but I gather it is quite expensive to give someone the level of interferon treatment that is needed to try to force leukemia into remission. I do not know if either of you are expert enough about that to comment on that.

But I assume that that would be an illustration of the kind of newer medicine that has now come on the scene that can take a deadly life-threatening problem and deal with it. It can intercept it, and perhaps in a certain number of cases solve it, in other cases extend life.

Any idea what that kind of treatment would cost in a broad range for someone who needs it?

Dr. GRAHAM. I have no idea what the absolute cost is. I think your example is well drawn. The ability in the oncologic area is probably one of the greatest success stories in American medicine in the last 30 years.

But every one of those success stories has a very tangible cost attached to it. You cannot just look at that out of context. I mean you cannot look at one patient with leukemia and say, "Well, we have decided we will not cover this." Let us say the answer to your question is $30,000 a year for 5 years. And somebody comes up and says, "We have the treatment. We have a 50 percent expectation that that leukemia will be in remission at the end of 5 years if $150,000 is spent."

Our system really requires each of us as providers to say we will do it. But once we do that in the aggregate, year after year, patient after patient, we come to a setting such as this morning to say the implication of those decisions in the aggregate is now something which we must reexamine—not just because we have 40 million people who do not have health insurance, who do not have access to the level of care at all.

Even if we did not have that problem, I suspect we would be sitting down talking about the aggregate level of health insurance be-

cause the United States looks so different than other organized systems.

Senator RIEGLE. Well then, if you go back to my Patriot missile example—and it is far from a perfect one—that is a success story. That is sort of an interferon analogy, I suppose, with leukemia. But in order to get the Patriot we bought a lot of weapon systems that do not work.

I mean we have airplanes that do not fly, and we have guns that do not shoot properly, and all kinds of other things. And out of an array of spending you get some that are great successes, such as we are seeing in this instance of the Patriot missile; and I assume that is exactly the same in medical research.

You go down a bunch of avenues and you spend a lot of money on a promising treatment concept. We are doing this in AIDS right now. You know, the AIDS research is to try to examine a whole series of alternatives, not knowing which one may turn out to be the one that works. There will be a lot that are tried and do not work and that consume a lot of money and a lot of effort.

Of course, I suppose the same kind of resource rationing decision comes up there. In other words, you know, how do we decide even among the array of problems to go after, which ones to pick. Do we pick cancers? Do we pick AIDS? Do we pick some other kind of health profile problem that is besetting a lot of people?

Having discussed this in all the ways that we have, I am getting the feeling coming through the testimony that in getting a more efficient system, a system that is fairer in that everyone gets some measure of access and coverage—you do not want somebody out there with a health problem who feels he or she has no place to go or cannot get timely care—that we are also starting to bump into some outer limits in terms of how much we can afford, what we can handle and manage.

I am hearing limits, by one word or another, coming through the testimony of everyone who is appearing here. That is, we are facing a situation where getting the coverage and the greater efficiency, we are still going to be confronted with some very, very difficult human questions of when we say yes and when we say no; and how much treatment may be affordable across an entire society at any one time, given the advance of the technology as we have been discussing.

Dr. Rorrie?

Dr. RORRIE. I think the focus today certainly has been on a particular segment of the population and the cost associated with our health care system. I think we cannot lose track also that health care—and what we do in health care also—has a very definite link to what we do with what some other people call infrastructure issues.

So if we somehow do not deal with the housing issues in many parts of the inner cities of this country, in terms of the quality of the housing and the availability of jobs and, therefore, an education to go with those things, then, for example, the number of 90 million visits that we currently have in emergency departments in this country will only continue to escalate, because people do not have the proper housing; they do not have the proper education, jobs, all the things that go on education to understand what is the

best way to take care of themselves, what is the best way to deal with the health care system in this country.

So I think obviously your hearing is a very important issue in a very important area that means a lot to all of us who deal with health care on a day-to-day basis. But we would also say, I think, at least from my perspective that there are some other infrastructure issues that we really need to grapple with in a coordinated fashion if we are going to deal with this health care cost issue.

Senator RIEGLE. Well, you are exactly right. And while that has not been the direct focus of our discussion today, it is important that it be put on the table as you have done.

Another related aspect to it is, whatever the system is going to be, if we are going to pay for it we have to be good producers as a country. We have to have an economic system where people not only are healthy and stay healthy, but have to be able to have jobs and generate income that comes back around to let us finance our national agenda.

So all these things interconnect in the end in terms of giving us the economic strength to have a good future.

I thank you all for your testimony today. It has been very helpful and we will continue to talk with you and draw upon you for your thinking.

The committee stands in recess.

[The hearing recessed at 12:39 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF STUART M. BUTLER

ABSTRACT

The American health care system suffers from the twin problems of rapid inflation and unacceptable gaps in coverage. The major cause of these flaws is the structure of perverse incentives in the current tax treatment of health care spending. This treatment gives most help to Americans in the highest tax brackets who enjoy generous company plans, and little or no help to struggling families without such plans.

The Heritage proposal would replace the current tax exclusion for company-based plans with a new refundable, above-the-line tax credit in the personal code for medical care and health insurance expenses. The percentage credit would be based on a family's total health costs compared with income. In addition, there would be a Federal requirement for all heads of household to obtain a plan including at least catastrophic protection for themselves and their families. Medicaid and Medicare would be retained, together with state-based risk pools for those who are uninsurable despite the new credit.

This budget-neutral reform should be introduced gradually, with credits introduced in stages and financed by reductions in the value of company plans that is excludable from employee taxable income. Other proposals to deal with malpractice costs, and to spur greater competition in the insurance industry, would complement tax reform, but are not an alternative to it.

Reforming the Health Care System

The American health care system suffers from two fundamental flaws. First, in helping ordinary Americans obtain protection from health costs, most government assistance through the tax code goes to those who need it least, and to those employed in certain types of business. Second, the incentives associated with that tax treatment discourage normal consumer-led pressure for efficiency. The result of these flaws is unacceptable inflation in the health sector and millions of American families without protection from health costs.

These problem cannot be corrected by tinkering with the system. At The Heritage Foundation we maintain that fundamental reform is needed to restructure current government help to provide most assistance to those who need it most, assuring all Americans of access to affordable health care. Reform should also create incentives for families to take reasonable account of cost in making medical decisions. And reform should enable basic health care decisions to be made by the patient and physician, not a government bureaucrat or a health benefits manager.

The key to accomplishing these goals is to reform the tax treatment of health care spending. Specifically, the plan put forward by scholars at The Heritage Foundation would:

• Phase out the tax exclusion for company-provided health plans. Employers would be required either to provide each worker with the cash value or the plan or continue to provide benefits. But in each case the amount would be added to the W-2 as taxable income. To compensate for the lost exclusion, a new, above-the-line refundable tax credit would be introduced in the personal code for money spent on health insurance, prepaid plans or direct services. The percentage credit would be based on a family's total spending compared with its income—the higher the ratio, the larger the percentage credit.

• Under a "health care social contract," legally require all heads of household to purchase a health plan containing at least catastrophic health insurance, for themselves and their families. As its part of the contract, government would guarantee the ability of families to discharge that obligation at reasonable costs, either through the new system of credits or by granting access to publicly sponsored programs, such as Medicaid, Medicare or subsidized high-risk insurance pools.

This plan would create a national health system with significant advantages over other proposals. First, it could be budget neutral, since it is based on a restructuring if the more that $50 billion currently provided each year through the tax exclusion. Second, Americans no longer would be hostage to employer decisions regarding health care, and could switch employment without losing insurance, or switch to a non-company health plan without losing tax benefits. Third, the proposal would provide direct help to the uninsured to join a health plan, without regard to their place of work. And fourth, it would encourage families to seek the best value for money in health plans and to obtain the plans that best meets their needs, triggering the normal market process whereby providers seek continuously to prune costs while improving quality, as plans compete for the family's dollar (not, as today, the company's dollar).

This proposal would have most impact if introduced as a comprehensive, one-step reform. But it could be introduced in steps. For instance, the current credit for the purchase of insurance for children not included in company plans, enacted last year, could be expanded first to uncovered spouses, then to out-of-pocket costs and eventually to all Americans, with the revenue at each stage derived from a cap on the exclusion for company plans. The Treasury estimates that a modest cap would yield sufficient revenue for reasonable credits. Furthermore, this tax reform strategy, although basic to reform, would be strengthened by many other reforms, such as those designed to tackle the malpractice crisis and to spur greater competition in the insurance industry.

Question 1: What does the Heritage proposal do for the uninsured?

Answer. The proposal would grant refundable tax credits for health insurance and services to low-income workers and their families. These families, which typify the uninsured, thus would obtain government help to pay for care no matter where they worked, or if family members worked full time. Nor would they lose coverage if they switched jobs or were temporarily laid off. If the credit system were insufficient to enable very-high risk Americans to afford insurance or to join a group plan at reasonable cost, these Americans would join a state-sponsored, subsidized insurance risk pool, or, if the State chose, be granted eligibility for Medicaid.

Question 2: Can average Americans really be expected to make sensible purchasing decisions regarding products as complex as medical care and insurance?

Answer. In the case of many minor services such as dental work, annual physicals and treatments for minor injuries the required medical knowledge is small, and consumer decisions would likely be based on such issues as cost, waiting time, choice of doctor and other important, but non-technical factors.

For catastrophic insurance and major medical services, however, the Heritage proposal envisions most Americans joining buyer groups for care and insurance, not purchasing either directly. when buying a health plan, knowledgeable consumers would carefully select the plan offering the features they want at the best price. Less knowledgeable Americans would either take the advice of an expert in whom they had confidence, such as their family physician or a consumer organization, or they could join a purchasing group that they felt would best represent their interests. Today of course, the only group they can join and enjoy tax relief is a company-based plan, which means that if the company does not insure a worker and family—or insure them adequately—they will often lack coverage. The Heritage plan provides an alternative group, with tax relief, for such families.

Alternative groups could be organized by such sponsors as a union, a church, a farm bureau, or a professional or trade association. They could also be groups of individuals with special medical needs, such as diabetics, seeking plans with particular services. In each case the individual would gain the economies of scale and bargaining power of the larger group, and could choose a group that arranged the desired package of insurance and services at the best price. Indeed, some of these alternative groups already offer their members health insurance packages, in spite of the only very limited tax breaks currently available.

Question 3: Wouldn't individual insurance be more expensive than employer-based group insurance?

Answer. Currently, individual health insurance policies are more costly due in large part to higher marketing costs associated with the fact that relatively few people now purchase health insurance individually. But if individual, or small group, buyers comprised a substantial segment of the market, competing insurers would be able to lower overhead costs.

Nevertheless, it is still likely that group insurance would have a market advantage, and that individual buyers would choose to join a group, since groups can bargain most effectively with providers and insurers. The Heritage proposal generally would reduce the administrative costs of group plans. One reason is that today's employer-based insurance involves considerable unnecessary administrative cost because insurers and benefits managers must try to limit the medical costs of workers who have few incentives to economize. Under a consumer-driven system, however, the user has strong incentives to economize, since he or she benefits from savings. Thus existing bureaucratic controls would be replaced in large part by the "controls" of "self-regulating" consumers, reducing administrative costs. A second reason is that with the same tax treatment for out-of-pocket and insurance costs, more Americans would pay directly for minor items, thereby reducing paperwork costs for claims.

Question 4: But if such groups did form, wouldn't insurers compete for the lowest risk families? Wouldn't such "adverse selection" leave many Americans with prohibitively high premiums?

Answer. Initially, many insurers would compete for healthy families, but this competition would drive down premiums and profit margins for insurers. This, in turn, would make the high-risk segment of the market more attractive to insurers. Furthermore, under the Heritage proposal, the government would give more generous tax relief to families facing high premiums and/or high out-of-pocket costs. Thus unlike today, where insurers will not cater to higher-risk because the premiums they would have to charge would be prohibitive, such families would have the extra money they need to afford the higher premiums appropriate to the services they need, making that part of the market just as attractive to insurers as the low-risk (but low premium) families.

While cross-subsidization would still occur under the Heritage proposal, the difference is that most of it would occur through the tax system, not through equal premiums. Thus, problems of adverse selection (another name for rational consumer choice!) would be removed. Moreover, subsidizing through the tax code is a far more precise and efficient method than the imprecise cross-subsidization achieved through equal premiums in company plans.

Question 5: But if the government provides generous credits for expensive insurance and treatment, wouldn't that increase the tax revenue losses to government and encourage Americans to buy extra, but unnecessary coverage?

Answer. Tax revenue losses would indeed increase for credits provided to high-risk families. On the other hand, the losses would be sharply reduced on the lower cost insurance and fewer direct medical services healthy Americans could be expected to purchase.

But total revenue losses on average likely would be significantly lower under the Heritage proposal than under current tax law for three reasons. First, the increased consumer sensitivity to cost would slow general medical costs, and hence tax losses on medical insurance purchases. Second, healthy families no longer would have the incentive to overuse medical services, again reducing tax losses. Although the credit would encourage a certain amount of over use, it would almost certainly be a less than is common today under company-paid plans. And third, even though millions of additional families would be eligible for tax relief, this would cost the government less than it does today when most of these families turn to Medicaid or receive uncompensated medical care, with the cost usually added to the medical bills of patients with tax-free company insurance.

Question 6: Most Americans today have their medical insurance premiums paid directly by their employer, and they do not have to worry about claiming back tax relief. Wouldn't the Heritage proposal lead to many Americans not buying insurance, or missing premium payments, and wouldn't lower-paid workers be unable to wait until the end of the tax year for their credits?

Answer. Under the Heritage proposal, all heads of households would be required to buy basic catastrophic insurance for themselves and their dependents, and credits would be available only for actual purchases of insurance or medical care during

the tax year. The "catastrophic insurance mandate" could be enforced in several ways. One way might be that when tax returns were filed, the family would receive a "proof of insurance" form from its health insurance company, much like a W-2 form, and this would have to be appended to the return. The form would give the cost of insurance, and certify that at least the legal minimum was purchased. If the proof of insurance forms were not attached, or did not indicate that the family was insured throughout the year, a penalty might be imposed.

Alternatively, the problem could be eliminated through a modest book-keeping requirement for employers. The tax credit available under the Heritage plan would be blended into the tax withholding system for employees. Thus a worker would claim adjustments based on his family's anticipated insurance and out-of-pocket expenses (just as he does today, based on such factors as the size of his family, and his mortgage interest payments), and withholding would be adjusted accordingly. If medical and insurance costs begin to run higher than expected, the withholding amount could be changed. Similarly, if the worker is entitled to a refundable credit, a monthly amount would be added to the paycheck by the employer, and deducted from the total tax withholdings sent by the employer to the IRS. At the end of the year, of course, the family would complete a tax form, including actual medical expenses that year, and the taxes would be adjusted.

In addition, employers could be required to take a deduction from each employee's paycheck to pay for health insurance, and send a check to the health insurance company of the worker's choice—much as many employers today deduct voluntary contributions for 401(k) pension plans. The amount of the check would depend on the insurance package chosen by the worker. Thus the employer would not pay the premium, but would assure that it was paid.

PREPARED STATEMENT OF GOVERNOR MICHAEL CASTLE

Good morning, Mr. Chairman and members of the subcommittee. It is a pleasure to be here on behalf on the nation's Governors to discuss the need to reform our health care system.

Health care reform is the number one priority of the National Governors Association this year. Under the leadership of our chairman, Booth Gardner, we have established a Task Force on Health Care, of which I am a vice chair. We are well aware that solving the complex and difficult problems that confront the Nation's health care system will require real dialogue and compromise from all levels of government and the private sector. We hope that this hearing will mark the beginning of a strong Federal-state partnership in the 102nd Congress to reach our mutual goal of access to affordable health care for all Americans.

THE PROBLEM

Our Nation's health care system is nearing a state of crisis. In 1983, the United States spent $357 million, or 10.5 percent of our gross national product (GNP), on health care. By 1989, those figures rose to more than $599 billion, or 11.9 percent of our GNP—that is $2,400 for every man, woman, and child in the country. If unchecked, health care costs are projected to rise to $1.5 trillion, or 15 percent of our GNP, by the year 2000—that's $5,000 per person.

Yet millions of Americans have limited or no access to the health care services they need. Approximately 31 million people are uninsured annually, and 37 million may be uninsured in any given month.

Further, health care costs have risen at twice the rate of inflation; as a result, employers are experiencing double-digit increases in premiums. Such increases are forcing difficult choices and many employers must deny coverage for dependents and cut back coverage for employees. Most small businesses are unable to afford health insurance for their employees.

Increasingly, health benefits have become a leading cause of labor conflicts and businesses are taking notice of how health insurance costs affect their ability to compete in the world market.

Governors are employers too. In fact, in some States, government is the largest single employer. And as employers, Governors suffer the same premium increases and face the same draconian choices as any other employer.

As this subcommittee may be aware, in July of 1989, the Governors appealed to Congress and the administration to halt the enactment of any further Medicaid mandates for a period of two years while we worked to find long-term solutions to the intertwined problems of inadequate access to care and escalating costs that place care beyond the reach of so many.

THE GOVERNORS' TASK FORCE

Since passage of their resolution, the Governors have moved aggressively to fulfill their commitment to seek solutions. Governor Gardner established our Health Care Task Force that is now working on two products that will be completed by August 1991—first, a detailed report on state options to increase access to health care and control costs, and second, a policy statement focusing on key reform issues requiring Federal action, such as restructuring Medicaid.

THE REPORT

Governors currently hold a number of important policy levers that we think we can use more efficiently and effectively to increase access and control costs in our states. Not only do we finance care directly through Medicaid and public health, but we also regulate insurance, license health care providers and facilities, and have some experience in allocating capital resources.

Our report will identify incremental steps states have already taken to expand care and control costs and will describe comprehensive ways states can restructure their health care financing and delivery systems. The report will guide states in reorienting their health care systems to emphasize preventive and primary care, outline steps Governors can take to help the working uninsured, and suggest options for expanding access to health care for the non-working population.

The report also will feature a wide range of options for cost containment. It will include several incremental and discrete strategies such as managed care, administrative reform, and medical tort reform, and innovative strategies such as state-level allpayor systems and global budgeting to control capital expansion. The Governors firmly believe cost containment is essential to ensure health care access. We also firmly believe that the state level is the appropriate place to make resource allocations. States are both large enough to provide an adequate market force and small enough to recognize special and different needs for different parts within our states.

Finally, the report will contain suggestions for Federal action to help states implement such reforms.

POLICY

As we develop our report, we are also working to develop a policy statement to be submitted for approval by all the Governors at the NGA annual meeting this August. The policy will focus on the key issues requiring Federal action to restructure the health care system and will most likely make specific recommendations on the future of the Medicaid program, changes in insurance practices, and small market reforms to enhance increased access to health insurance.

MEDICAID

Mr. Chairman, I would be remiss if I did not touch on the unique problem of Medicaid from the Governors perspective. But I want to stress that we understand clearly that the Medicaid resources will play a key role in expanding access to care for those who fall outside the employer insurance system.

Escalating costs and limited access to health care have had a profound impact on the direction of the Medicaid program. Medicaid was created in 1965 to provide health care to women and children eligible for Aid to Families with Dependent Children (AFDC) and to the aged, blind, and disabled persons eligible for Supplemental Security Income (SSI). But over the years it has become a catch-all program to address the needs of a wide variety of special populations it was not designed to serve. And four years of unrelenting federally mandated expansions have created a monstrous program that is next to impossible to administer and finance.

Medicaid has lost a clearly defined purpose. It now struggles to serve not only its categorically eligible clients but also: (1) pregnant women and children with incomes above AFDC eligibility levels but below certain percentages of poverty; (2) near-poor elderly individuals and chronically ill children in need of long-term care; (3) mentally retarded and mentally ill persons; and (4) poor elderly individuals who are covered under Medicare.

These mandated expansions cost big money. Medicaid mandates enacted by Congress over the last four years will cost states $17.4 billion between 1991 and 1995. Mandates enacted last year will cost an additional $3 billion between 1991 and 1995. As the fastest growing portion of state budgets, Medicaid spending increased by 18.4 percent and consumed 14 percent of state budgets last year. It is expected to consume 17 percent of state budgets by 1995.

Further, Medicaid is not appropriately oriented toward the provision and delivery of preventive and primary care services. As Federal mandates dictate program priorities the primary objective of the program and its ability to serve the very population it was initially created to help is obscured both in focus and available resources.

As the Governors wrestle with the long-term role of Medicaid in a restructured health care system, we have asked some of the following questions:

1. Should Medicare benefits be enhanced to circumvent cost shifting to the Medicaid program? If the original intent of the Medicare program is to protect the elderly and disabled, it should honor that commitment and assume its financial responsibility and promise.

2. Would it be more appropriate to move long-term care out of the Medicaid program? Because Medicaid is an acute care program with an institution bias, it may not be the best program to provide long-term care services. A new program designed to meet both the social and health care needs of the elderly may provide a more appropriate approach to this population. We might also want to consider developing a national catastrophic care program that would include insurance for long-term care.

3. Would it be more appropriate to establish separate programs for other specified Medicaid populations? As with long-term care for the elderly, establishing a separate program designed to meet the unique financing and service needs of the mentally retarded and mentally ill population may make more sense.

4. Is it time to break the link between Medicaid and categorical eligibility from welfare and establish a new program of publicly funded health insurance to meet the health needs of diverse populations? This would simplify the eligibility process and provide flexibility for adapting the Medicaid program to future health system reform.

5. Shouldn't states be given the flexibility with Medicaid to develop and use some of the same cost-saving strategies used by the private sector and Medicare? For example, Medicaid is precluded by law from the widespread use of managed care initiatives, and Federal mandates affect how states reimburse providers. Flexibility is essential if states are to serve as laboratories to implement innovative systems of care and cost containment strategies.

SHORT-TERM MEDICAID POLICY

Recognizing that the answers to these questions are difficult and must be considered in the context of larger system reform, during our recent winter meeting, the Governors also approved a short-term Medicaid policy to provide the states with immediate relief from some of the pressing problems presented by Medicaid. Swift congressional action to implement our policy will give the Governors the resources and capability to move forward to long-term solutions. In the policy, we call on Congress and the administration to work with us to make the following changes in Medicaid:

- Congress should delay the mandated implementation of the 1990 Medicaid mandates for two years. This will give Federal and state governments time to assess the depth of the recession and the opportunity to develop long-term solutions for the restructuring of the Medicaid program.
- States must not be expected to implement any Medicaid program changes until the Health Care Financing Administration has published final regulations to guide the program administration.
- States must be allowed to maintain their complete authority to raise funds to match Federal Medicaid dollars without restriction from the Federal Government.
- To promote cost control and efficiency, states should be encouraged to continue innovations in provider payment methods.

In addition, we ask for relief from three particularly troublesome mandates enacted in the last four years. These include qualified Medicare beneficiaries, nursing home reform, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) mandates. We believe strongly that:

- Congress should assume full financial responsibility for all low-income Medicare beneficiaries who are not otherwise eligible for Medicaid. This will appropriately return to the Federal government the responsibility to protect low-income Medicare beneficiaries.
- States should be considered in compliance with the OBRA 1987 nursing home reform law if a comparable quality assurance program is in place or developed. The statutory language of this law permits limited state flexibility and puts Congress in the position of micro-managing the program at great financial costs to states.

• Congress should modify the OBRA-1989 technical EPSDT amendment, which added unforeseen costs to Medicaid, by (1) clarifying that states may identify qualified screening providers and require that such providers provide all screening services; and (2) giving states authority to limit EPSDT services to those currently offered in a state's Medicaid plan.

CONCLUSION

Mr. Chairman, the Governors are in agreement that our health care system must be reformed. Because we are on the front lines, Governors see the effects of our failure to provide care to so many of our citizens every day. We are committed to identifying ways in which states can respond to out-of-control costs and inadequate access to care.

We also recognize that ultimately this crisis demands a national solution. But we caution the Congress not to assume that having the Federal Government take total control of the system will be the right solution. The real issue in health care reform is how to ensure that financing meets service delivery needs at the most local level.

I might add one last word of caution. Congress seems to be moving in the direction of incremental changes to our health care system, believing that we have neither the money nor the necessary consensus to implement a whole new structure overnight. But incremental changes must be made in the context of agreement among all the parties about where we are ultimately going. And we must be sure that we implement our incremental changes in the right sequence and with an understanding of how one incremental change will impact the rest of the system. I would suggest this means that we must continue to talk about our common goals and the best way to incrementally achieve them.

We thank you, Mr. Chairman, for your continuous effort to work with us and our organization as you proceed with your plans. We believe the solution is a real partnership not only among levels of government, but with the private sector as well.

The nation's Governors stand ready to work with you, Mr. Chairman. I would be happy to respond to any questions.

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News Release

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GOV. CASTLE URGES STRONG FEDERAL-STATE PARTNERSHIP TO REFORM HEALTH CARE, INCREASE ACCESS, CONTROL COSTS
Short-Term Action Needed While Reform Measures are Developed

WASHINGTON, D.C. -- The nation's health care system is nearing a state of crisis and reforming it to ensure access to affordable health care for all Americans will require "real dialogue and compromise from all levels of government and the private sector," Delaware Gov. Michael N. Castle said today before the Senate Finance Subcommittee on Health for Families and the Uninsured.

Gov. Castle, a vice chairman of the NGA Task Force on Health Care, said his task force is developing options for states to use to increase access to health care and control costs. At the same time, he said Congress and Governors must address the continually rising costs and expansions in the Medicaid program and their impact on states.

The current crisis in the U.S. health care system "demands a national solution," he said, "but we hope that Congress will not assume that having the federal government take total control of the system will solve the problem. The real issue in health care reform is how to ensure that financing meets service delivery needs at the local level."

While the Medicaid program plays an important role in the U.S. health care system, Gov. Castle said "it has become a catch-all program to address the needs of a wide variety of special populations it was not designed to serve. And four years of unrelenting federally mandated expansions have created a monstrous program that is next to impossible to administer and finance."

Mandates enacted over the past four years will cost states $17.4 billion between 1991 and 1995, Gov. Castle said. Mandates enacted last year will cost states an additional $3 billion over

increased by 18.4 percent and consumed 14 percent of state budgets last year, he said, and the program is expected to consume 17 percent by 1995.

Despite the enormous financial resources being poured into Medicaid, the program is not appropriately oriented toward preventive and primary care, he said.

"Medicaid has lost a clearly defined purpose," the Governor said. It now struggles to serve not only those it was originally intended to serve -- poor women and children and certain aged, blind, and disabled persons, but other populations.

Earlier this month, governors adopted a new short-term Medicaid policy that asks Congress to provide some immediate relief as governors work to address long-term solutions. "Swift congressional action to implement our policy will give the governors the resources and capability to move forward to long-term solutions," Castle said.

The policy calls on Congress and the administration to work with Governors to make the following changes in Medicaid:

- Congress should delay the mandated implementation of the 1990 Medicaid mandates for two years. This will give federal and state governments time to assess the depth of the recession and the opportunity to develop long-term solutions for the restructuring of the Medicaid program.

- States must not be expected to implement any Medicaid program changes until the Health Care Financing Administration has published final regulations to guide the program administration.

- States must be allowed to maintain their complete authority to raise funds to match federal Medicaid dollars without restriction from the federal government.

- To promote cost control and efficiency, states should be encouraged to continue innovations in provider payment methods.

In addition, the policy asks for relief from three particularly troublesome mandates enacted in the last four year. These include qualified Medicare beneficiaries, nursing home reform, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) mandates. Governors believe strongly that:

- Congress should assume full financial responsibility for all low-income Medicare beneficiaries who are not otherwise eligible for Medicaid. This will appropriately return to the federal government the responsibility to protect low-income Medicare beneficiaries.

- States should be considered in compliance with the OBRA 1987 nursing home reform law if a comparable quality assurance program is in place or developed. The statutory language of this law permits limited state flexibility and puts Congress in the position of micro-managing the program at great financial costs to states.

- Congress should modify the OBRA-1989 technical EPSDT amendment, which added unforeseen costs to Medicaid, by 1) clarifying that states may identify qualified screening providers and require that such providers provide all screening services; and 2) giving states authority to limit EPSDT services to those currently offered in a state's Medicaid plan.

Gov. Castle said Governors agree that our health care system must be reformed. "Because we are on the front lines, Governors see the effects of our failure to provide care to so many of our citizens every day. We are committed to identifying ways in which states can respond to out-of-control costs and inadequate access to care."

He said the Task Force on Health Care is working to identify options.

The task force is preparing a report that will identify steps states have taken to expand care and control costs and will describe comprehensive ways states can restructure their health care financing and delivery system. In addition, the task force is developing a comprehensive policy statement on key reform issues requiring federal action to be considered by the governors at their annual meeting in August.

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PREPARED STATEMENT OF ROBERT GRAHAM

Mr. Chairman and members of the subcommittee, I am Robert Graham, MD, Executive Vice President of the American Academy of Family Physicians. I am accompanied today by Colin C. Rorrie, Jr., Ph.D, Executive Director of the American College of Emergency Physicians. I am pleased to appear today representing the Physician Organizations for Access to Care Coalition, an organization comprised of 18 physicians organizations representing a broad range of medical specialties.

The coalition commends you for the leadership you have shown, Mr. Chairman, in your willingness to confront this issue. You have been an important force through your work with the Senate Bi-partisan Working Group in continuing to keep this issue in the public eye, and we look forward to working with you.

As physicians, we are concerned that as the U. S. health care system becomes increasingly competitive and cost-conscious, the plight of the uninsured will only worsen. Across America, physicians are committed to finding solutions to ensure adequate and affordable health care coverage for physical and mental illness for all our citizens. The Physician Organizations for Access to Care Coalition was formed last year to develop a consensus within medicine concerning a solution to this significant problem. The organizations of the Access to Health Care Coalition believe that the preferred approach is one that builds upon the strengths of the public/private system of insurance, and that utilizes the traditional approach of employer based insurance.

CHARACTERISTICS OF THE UNINSURED

The number of uninsured Americans has increased significantly since the late 1970s, when approximately 26 million people were uninsured. During the recession of the early 1980s, the number of uninsured people increased dramatically, reaching approximately 34 million in 1983. Since that time, there have been some changing estimates of the number of the uninsured, ranging from 31 to 37 million. The most recent estimates are that about 31 million are uninsured.

The uninsured are a surprisingly heterogeneous group. According the National Medical Expenditure Survey (NMES), the employed uninsured, with their dependents, accounted for 75 percent to 80 percent (about 24 million) of the uninsured population. Of the 24 million employed uninsured, 85 percent worked for firms of fewer than 100 employees, while 48 percent worked for firms with fewer than 10 employees. Many of the employed uninsured are low wage earners. About one-third earn $10,000 or less annually. Approximately 30 percent of the uninsured have incomes below the Federal poverty level.

It is estimated that about 1 million of the uninsured are persons who are considered to be "medically uninsurable." These persons are unable to obtain health insurance coverage, or can obtain such coverage only at extremely high rates because of poor health status, previous medical history, or employment in a medically hazardous occupation.

In addition to the uninsured, millions of other Americans lack adequate health insurance coverage. Thus, while these persons have some health insurance, they still may be financially vulnerable, and may lack access to necessary health care services.

REASONS FOR INCREASES IN THE NUMBER OF UNINSURED

The rise in the uninsured population is most often attributed to a combination of factors: Medicaid's failure to keep pace with the increase in the number of people in poverty; the high unemployment from 1980 to 1982, followed by shifts in employment away from manufacturing to relatively low-paying service sector jobs; and increasing numbers of parttime workers.

While the number of persons on Medicaid has increased during the 1980s, the number of persons below the poverty level has risen even more sharply. As a result, Medicaid, which initially covered over 60 percent of the poor, now covers only about 40 percent of this group.

The number of Americans covered by employer based insurance increased dramatically during the period from 1946 to 1979. While there has been a significant increase in the number of employed persons since 1980, the number of workers and dependents covered by employer-based health insurance has remained constant at about 141 million individuals.

A reason frequently given for the increasing number of employed uninsured has been the major shift away from manufacturing jobs, with high rates of employer-provided insurance, into the service and retail sectors, with lower rates of employer-provided insurance. There has also been a growth in the number of small business-

es, which frequently do not provide health insurance. In addition, there has been an increased use of part-time workers, who generally do not receive health insurance.

A final reason cited for the increase in the number of uninsured is that fewer spouses and dependent children are being covered by employer health plans. Some plans do not offer such coverage, and others make it too costly for many workers to afford. In addition, a growing number of workers who are offered and can afford coverage simply decline it.

The major reason that some businesses do not provide health insurance appears to be the cost of such coverage. The over 600 state mandated benefit laws are significant factors in increasing the cost of coverage. The cost of coverage is particularly high for small businesses, which tend to be less profitable and face large administrative costs. In addition, small businesses that have employees in poor health may not be able to purchase coverage at any price.

Studies already indicate that the uninsured use less medical care than the insured, and that they are less likely to seek care when ill. As physicians, we are concerned that this situation will only become worse. Timely and appropriate health care should be available to all who need care.

A BLUEPRINT FOR COVERING THE UNINSURED

As members of the Physicians Access to Care Coalition, we are committed to working with Congress and the Administration to achieve legislation embodying the principles explained below. Further, to meet the immediate challenge of caring for the uninsured population, and the longer term challenge of a better health care system for all our citizens, the medical profession recognizes its responsibility to work with others to ensure that quality care is delivered in a cost efficient manner.

The medical profession has historically maintained that health care services be available to all our citizens, and is strongly committed to finding solutions to ensure access to health insurance for those in this country who currently lack coverage.

The coalition strongly believes that the traditional approach of employer based insurance should be encouraged. Employers should be required to provide health insurance to their employees and dependents, with appropriate cost-sharing by employees.

We recognize that such a mandate could create a potential financial burden on small businesses. Therefore, we believe Congress should include provisions that would ameliorate the impact of this requirement. These provisions could include tax relief, subsidies, phased-in implementation, risk pools, and other reforms which would make insurance more available and affordable.

While the coalition is pleased with recent expansions to cover more individuals through the Medicaid program, we believe that Medicaid must also be both expanded and substantially improved, including the enactment of minimum eligibility and benefit levels. There must also be incentives to increase provider participation.

For those not eligible for employer-based insurance, and whose incomes are in excess of the enhanced Medicaid eligibility level, provision should be made for participation in a subsidized program with cost-sharing on a sliding scale premium basis.

In addition, the coalition believes that health insurance programs, whether public or private, should provide access to basic physical and mental health benefits.

The members of the coalition also understand that any health care reform proposal must attempt to correct some the weaknesses and deficiencies within the health care system by addressing problems such as medical liability, the need for insurance market reform, and measures to reduce administrative burdens.

Mr. Chairman, the health of the nation is reflected in the health of its people. We can do no less than provide for the health of our citizens. On behalf of the coalition, we urge you to take action on this vital issue.

ACCESS TO HEALTH CARE COALITION MEMBERS

American Academy of Facial Plastic ad Reconstructive Surgery
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology—Head and Neck Surgery
American College of Emergency Physicians
American College of Rheumatology
Aerospace Medical Association
American Medical Association

American Pediatric Surgical Association
American Psychiatric Association
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Internal Medicine
American Society of Plastic and Reconstructive Surgeons
College of American Pathologists
Renal Physicians Association

PREPARED STATEMENT OF JEFFREY H. JOSEPH

Since that time, the health care system has gone through significant changes, brought about in part by various laws, including the Health Maintenance Organization Act, the Employee Retirement income Security Act, continuation of coverage requirements under the Consolidated Omnibus Budget Reconciliation Act, and Medicare payment reform. In addition, numerous commissions, task forces, and working groups have examined and addressed these issues. Yet problems remain and, indeed, seem to be intensifying.

The Chamber has continued its health care reform efforts, developing policy recommendations aimed at controlling costs and facilitating access. I would emphasize that the attached Statement on Access to Health Care is not the Chamber's final word on health care; rather, it is an evolving document. We did not set out to develop a comprehensive "solution," but to recommend workable policies targeted at the various problems underlying our health system.

The Chamber also has been actively working with numerous businesses and associations over the past two years as part of a coalition, the Partnership on Health Care and Employment. The Partnership was formed to explore positive solutions to the health care affordability problem, while examining the negative side-effects some proposals would have on the health system and the economy generally. For example, the Partnership last fall published a study by CONSAD Research Corporation of Pittsburgh, Pennsylvania that revealed that as many as 3.5 million jobs could be lost as the result of mandated employer-provided health insurance. We believe that a tax-based "pay or play" mandate would be just as disastrous in terms of employment impact, particularly among low-wage earners, minorities, and women.

Coalition efforts are a very important element in moving the health care debate forward. There are powerful and diverse interests involved in this debate: business, unions, consumers, providers, insurers, and government at all levels. We all agree that something must be done, but there is no consensus on the shape of comprehensive health care reform. There is broad agreement, however, on a number of issues.

For example, the Chamber participated in the Children's Medicaid Coalition, which included providers, children's advocates, insurers, and other business groups. This broad coalition successfully supported expanded Medicaid eligibility for poor children, who, at first blush may not seem to be a natural constituency of the U.S. Chamber of Commerce. But they are tomorrow's adult citizens and workers, and their health and social needs, if not addressed today, will be more difficult and expensive to deal with later.

We should continue to move forward in areas where broad consensus exists. The multifaceted nature of the problems facing the health care system, as well as the political and budgetary dynamics of the debate, suggest an incremental approach. The requisite consensus seems to be developing in a number of areas, including reform of the small group health insurance market.

But reforming the health care system will not be an easy process. I know that members of this committee and the Labor and Human Resources Committee have participated in the Bipartisan Bi-Committee Working Group and have struggled with these issues for nearly two years.

Many people seem to be searching for a "magic bullet" solution. The instinctive reaction to these problems is to throw more money at them. This tactic, employed over the past 20 years, has proven to be a failure. But given the current budget situation and the ability of all purchasers of health care, be they employers or employees, to pay more, that is not a realistic option. We must think creatively and search for solutions that not only require fewer dollars, but also make the system more efficient.

While discussions of health care reform have largely centered upon access, that apparent problem is instead a symptom of the fundamental health care problem: out-of-control-costs. However, addressing the factors that are driving health costs, of course, is easier said than done. The components are complex and interrelated.

Among them: an aging population that is using health services to a greater extent; public health care challenges, such as AIDS and drug abuse, which are straining the capacity of the system in many areas; a system, which, for all of its high-technology diagnostic capability on the practice side, is restrained by an antiquated administrative system; a litigious society, which has spawned the widespread practice of "defensive medicine;" and government regulations, including state benefit mandates and continuation of coverage requirements, which perversely render health insurance unaffordable for many small businesses.

I believe fresh, creative thinking is sorely needed in this debate. I am not here to tell you that I have all of the answers, nor am I going to recite the Chamber's health policy recommendations. Of course, I would be glad to answer any questions you may have regarding them. But I would like to take this opportunity to raise some issues and suggest areas the Chamber is examining and we believe deserve further exploration by Congress.

First, we need to bring the entire health care system into the 21st century. We should explore how new information technologies can be applied to the health care system to save budget dollars (as well as economic resources on the part of the public in the health care system that do not show up in the budget process, the so-called "hidden taxes" of government) by reducing paperwork and regulatory costs. Paperwork reduction and regulatory relief has been an ongoing legislative issue for the Chamber and other diverse groups, including state and local governments. Our goal: to get a "bigger bang for the buck" by better managing our information management resources.

We have witnessed tremendous productivity gains in the manufacturing sector as a result of the application of new information technology. The labor-intensive service sector, where productivity gains are more difficult to quantify, has been slower to adopt and integrate information management technology. I believe there is enormous potential for savings in the health care arena. imagine what even 5 percent savings—not an unrealistic expectation—could mean in our $600 billion system in terms of expanding access. Specifically, $30 billion that is already in the system could be redirected to provide health insurance coverage to those who have none.

The pace of change in information technology has been phenomenal and the potential even more incredible. Ten years ago when we were talking about the cost-saving potential of information management technology, most of us were using typewriters; today most of us cannot imagine life without computers.

The impact of information technology on the health system goes beyond administrative efficiency and to the heart of patient care. For example, the establishment of a computerized medical records system could result in the more effective delivery of care to individual patients, while increasing the ability of providers and payers to monitor and improve the quality, appropriateness, and efficiency of medical care.

One step to encourage this efficiency right now is to support the Paperwork Reduction Act (PRA), which is up for reauthorization by the Senate Governmental Affairs Committee. The Chamber is supporting provisions which would better enable the Office of Management and Budget to operate as a vanguard of information resources management—applying new information technologies—among the Federal agencies. The health care system will surely benefit from the centralized management resulting from a strong PRA and Office of Information and Regulatory Affairs.

Another area with great potential for squeezing additional dollars from the system is elimination of defensive medical practices, i.e., physicians ordering tests and procedures that may not be medically necessary in order to protect themselves from unwarranted malpractice suits. It is estimated that as much as $50 billion is spent on defensive medicine, often in the form of unnecessary and duplicative diagnostics.

Technology also can play a role in reducing liability costs. For example, in Boston several hospitals use a software program called Chart Checker, which double checks emergency room physicians' work to ensure appropriate care was delivered. Malpractice insurers are now offering 20 percent discounts to physicians working in hospitals where this system is in place.

The Chamber supports medical professional liability reform. This is an issue that needs no more study. The time for action is now.

We also support as the key to improving quality and eliminating ineffective care, a national effort led by physicians and scientists to develop practice guidelines, review protocols, and assessments based on outcomes. We believe development and implementation of national medical practice standards should be supported by expanded Federal funding, and we are pleased that this effort is now being spearhead-

ed by the Agency for Health Care Policy and Research (AHCPR). We believe the scope of AHCPR's work should be expanded beyond the Medicare population.

In addition, this process should be taken one step further, with the use of practice standards tied to protection from malpractice claims under state law. The seeds of this approach already are present in the peer review organization (PRO) provisions of the Medicare law. Section 1320c-6 of Title 42 of the U.S. Code now protects any health care provider from civil liability on account of action taken using due care and in compliance with "professionally developed norms of care and treatment" applied by a PRO.

Practices guidelines help everyone in the health care chain. They offer physicians a powerful tool for coping with overwhelming amounts of information, and provide a means of lowering their own liability risks. They offer the patient the best available assessment of the effectiveness of care he or she is about to receive, and the assurance that the benefit is worth the risk. Finally, practice guidelines offer payers the assurance that they are getting value for the dollars spent, and provide a sound basis for selecting preferred providers.

Finally, I raise an issue that to an extent falls outside the parameters of the health care system, yet has a substantial impact on it—substance abuse. Business is very concerned about the use of illicit drugs among the nation's workforce. While the rate of drug use is twice as high among the unemployed versus the employed, the fact remains that 76 percent of adults who use drugs are employed.

In the workplace, substance abuse results in decreased productivity and increased medical claims, absenteeism, accidents, and employee theft. Awareness of this problem has increased among employers, who are taking steps—including drug testing—to eliminate drugs from the workplace. The Chamber supports appropriate Federal certification of testing laboratories; a uniform Federal drug testing standard that preempts diverse and often highly restrictive state requirements; requirements for confirmatory measures applied to all initial positive tests; and testing procedures assuring confidentiality, chain-of-custody, and opportunity for individuals to provide a legitimate explanation for positive results. Senator Orrin Hatch is expected soon to introduce legislation which would provide appropriate regulation of employer drug testing programs and would preempt state and local laws.

My goal in testifying today has been to raise issues that the Chamber believes are important within the context of the health care debate, but currently are not being adequately addressed. If we are to achieve true reform of the system, we must focus attention on some the underlying problems and craft targeted solutions. We must move away from the failed policies of the past two decades, which only try to identify new sources of revenue, without addressing the factors fueling health inflation.

Mr. Chairman, the Chamber commends you for your leadership in this area and stands ready to assist you as you continue to work on these issues.

U.S. Chamber of Commerce

Washington, D.C. 20062

STATEMENT ON ACCESS TO HEALTH CARE

I. COMMITMENT TO AN INITIATIVE ON COST, QUALITY AND ACCESS

A policy goal of the U.S. Chamber of Commerce is to increase financial access to health care, constrain health care costs and enhance quality. As health care costs climb nationally, the issue of financial access to care is inextricably linked with the issues of costs and quality. These three issues must be dealt with in tandem in order to forge a consensus of payers, providers and consumers.

II. GOAL: REDUCE THE NUMBER OF UNINSURED PERSONS BY TWO-THIRDS TO THREE-QUARTERS WITHIN A REASONABLE PERIOD OF TIME, AS PART OF A LONG-TERM COMMITMENT TO UNIVERSAL FINANCIAL ACCESS TO CARE

The Chamber supports, as a long-term goal, a system of public and private insurance that would assure universal financial access to appropriate health care. Even while the nation searches for the means to achieve that long-term goal, the Chamber supports immediate action to lessen the number of uninsured through a mix of public and private initiatives. A reasonable target for such short-term steps would be to reduce the number of uninsured by two-thirds to three-quarters within a reasonable period of time. Such an effort will require a partnership of the public and private sectors with neither sector asked to undertake financing burdens more appropriate to the other.

III. PROPOSAL: EXPAND MEDICAID TO ADDRESS THE NEEDS OF THE POOR AND NEAR-POOR

Approximately 32 percent of the uninsured population is poor -- defined as those with incomes below the federal poverty level. Currently, only 40 percent of Americans with incomes below the poverty line receive assistance from the Medicaid program. Differing state priorities and a growing elderly population with chronic care and nursing home needs have diluted the effect of this federal/state program originally designed to increase access to basic health care for the indigent. The U.S. Chamber of Commerce supports a four-part plan to address the health care needs of the poor and near-poor who do not have financial access to primary care coverage:

A. Assure basic Medicaid coverage to all Americans with incomes below the federal poverty level, restoring the original intent of this program and defining clearly the public sector's responsibility.

B. Allow persons with incomes between 100 and 150 percent of the federal poverty level to purchase, for a sliding-scale premium, primary care coverage through Medicaid.

C. Permit persons with incomes above the poverty level who have large medical expenses to "spend down" and become eligible to receive full Medicaid coverage once income is reduced to the federal poverty level.

D. To ease an individual's transition from welfare or Medicaid, provide states the option of paying Medicaid-eligible employees' share of premium and other costs where private employer-based coverage is available.

In recognition of state and federal budget constraints, the Chamber supports various options for phasing-in expanded Medicaid coverage, within the following priorities:

-- Mothers and children, with the youngest children receiving greatest priority;

-- Phase up medical eligibility by percentage of poverty level, beginning with the "poorest poor";

-- Primary care coverage.

IV. PROPOSAL: PROVIDE ACCESS TO STATE POOLS FOR HIGH RISK INDIVIDUALS

A small but socially significant percent of the uninsured population is comprised of nonpoor persons who are unable to purchase private health insurance because they are substandard health risks. The U.S. Chamber of Commerce supports federal legislation which would require establishment of state pools for uninsurable individuals, with losses financed by state general revenues or other broad based funding. Thus far, 16 states have established such risk pools.

V. PROPOSAL: PROMOTE EXPANDED VOLUNTARY COVERAGE THROUGH THE WORKPLACE

Approximately two-thirds of the uninsured population has some nexus to the workplace (i.e. workers, spouses or dependents). The problem among this population is especially prevalent within the small business sector where normal insurance administrative and underwriting mechanisms can make affordable insurance difficult to obtain. The Chamber is committed to finding ways to extend private, voluntary insurance coverage without at the same time producing job loss. Part of this effort must involve creating cost containment and quality improvement inducements that will encourage employers to expand coverage. The Chamber supports the following specific proposals:

A. Self-employed persons and unincorporated firms should be given a 100 percent deduction for health benefits costs. Unincorporated firms are about half as likely as other companies to provide health care coverage to owners and workers.

Currently, these firms may deduct only 25 percent of these costs and even this deduction will lapse at the end of 1989.

B. Multiple Employer Trust (MET) arrangements should be encouraged. These are group arrangements formed to help small firms obtain health care coverage on a more cost-effective basis than such a firm might be able to achieve alone. Use of improved cost containment, quality and appropriateness methods in these programs can make them affordable to larger cross section of employers. However, numerous federal and state regulatory impediments have discouraged the proliferation of these arrangements. If necessary, such impediments should be preempted by federal action.

C. The private health insurance and HMO industries must make special efforts to guarantee the availability of affordable health insurance to small businesses. To that end, insurance underwriting practices that prevent the pooling of good and bad risks within small employer pools must be constrained. Specifically, the insurance and HMO industries should give consideration to: (a) limiting medical underwriting of individuals within a firm (so that the whole group is accepted or not); (b) guaranteeing renewal of a group, at pooled rates, once it has been accepted (no renewal underwriting); (c) imposing no new pre-existing conditions on an individual who has been continuously insured if such individual is changing employment or coverage; and (d) providing a reinsurance pooling mechanism to spread risks among participating insurers and HMOs and to provide direct access to small employers who have otherwise been rejected. Any losses from such a reinsurance pool should be shared fairly based on who benefits from the mechanism.

D. State-level benefit mandates and barriers to managed care programs should be preempted. More than 640 specific state mandates now require insurers to include particular benefits in health plans. (e.g., mental health or chiropractic coverages) which make insurance more costly to employers with insured plans.

There is increasing legislative activity at the state level which has the effect of undercutting cost-containment efforts by limiting managed care arrangements. This involves such measures as limitations on the ability to form preferred provider arrangements or to provide economic incentives to employees to select such arrangements. Such barriers to managed care should be removed by federal or state action.

E. Federal benefit mandates (e.g., Section 89, COBRA) should be repealed or simplified for employers.

VI. PROPOSAL: PROMOTE THE DEVELOPMENT OF NATIONAL MEDICAL PRACTICE STANDARDS TO ASSURE APPROPRIATE AND EFFECTIVE CARE

A significant percentage of services delivered in our health care system are judged by researchers to be either inappropriate or ineffective. Further, research has shown wide variations in the use of procedures across different geographic regions with no apparent medical justification. The development of practice guidelines, review protocols and outcomes-based assessments through a national effort led by physicians and scientists is the key to removing this degree of waste from the system. Use of such standards with due care by physicians should carry with it protection from unwarranted malpractice claims. The Chamber therefore supports:

A. A national medical-scientific effort, supported by expanded Federal funding, to develop and implement national medical practice standards; and

B. Tying the use of such standards by physicians to protection from malpractice claims under state law, provided the physician has used due care in their application.

APPROVED BY THE BOARD OF DIRECTORS JUNE 14, 1989
REVISED NOVEMBER 8, 1989

PREPARED STATEMENT OF ROBERT S. MILLER, JR.

I appreciate the opportunity to share with you our views on why reform of the U.S. health care system is essential. The issues that are staring us in the face involve fundamental equity for uninsured citizens and grave problems of affordability and competitive viability for business.

The manner in which this nation finances the delivery of health care and assures its citizens access to care must and will change.

The most pragmatic reason change will occur . . . indeed the reason change is assured . . . is that given the current rate of growth in health spending, and even assuming the Administration's recent forecast of future economic growth in the economy can be sustained indefinitely, in 43 years, little over half the lifetime of someone born today, health care will consume 100% of this nation's GNP. Even the AMA will agree this is not tenable.

Health spending in America is clearly out of control. We spend almost 40% more per capita than the second most expensive country (Canada). Further, were we to consume health services in America at the same rate they do in West Germany and Japan, we would have $250 billion per year available to redeploy in our economy.

More fundamentally, American citizens are not well served by their country's health care system (more accurately, non-system). For some it delivers superb care. Others are essentially excluded from care until they are gravely ill. For all, it extracts an extraordinarily heavy financial toll which diminishes the economic vitality of many of the nation's employers and reduces everyone's standard of living.

Chrysler is quite concerned about the competitive damage inherent in the dramatic difference between U.S. and foreign health costs. A study of 1988 experience established that seven hundred dollars of the cost of every U.S.-built Chrysler car went to support the U.S. health system. Cost differences described above contributed to foreign automakers having a $300 to $500 per car advantage over us due to health costs alone. Domestic companies are likewise at a disadvantage compared with new foreign-owned firms locating in America which, while offering similar benefit plans, employ a much younger workforce and are a generation away from their first retiree.

In addition, excessive health costs reduce the disposable income of American consumers, hurting all businesses.

Business is quite limited as to what it can do in response to this problem, other than managing its benefit programs as effectively as possible. It cannot import a cheaper product from abroad. Those involved in competitive markets (like the fiercely competitive automobile business) cannot raise prices at will to recoup higher health costs. Instead, what results is a classic squeeze on profits. Lower profits reduce the funds which would otherwise be available for investment in research, new products and job creation. Lower profits also result in a reduction of tax revenues for investment by government in infrastructure improvement, including vital areas such as education.

Chrysler is convinced that to accomplish overall health system reform, satisfying business concerns regarding cost and public concerns regarding the uninsured, government must be involved in the solution. We cannot continue with the private sector doing its own thing, pitting large buyers against small ones, and permit the public sector, the only one empowered to pass laws and shift costs, to operate its enormous health plans without regard to their impact on private sector payers. Coordination is required.

Sadly, however, because we do not have a health policy in this country, we lack coordination between public and private sector health plans. As a result, the public sector has the opportunity to control *its* spending by taking steps which lead to costs being shifted to private sector payers. For example, Medicaid today covers only 40% of the poor. For those it does cover, it pays doctors only 66% of Medicare rates. However, state and Federal legislators are well aware that America is a humane country that the poor not covered by Medicaid will get care *if* they get sick enough and end up in some hospital emergency room. Accordingly, they have little incentive to face the tax payers with a request to adequately provide for these needs when they have the benefit of de facto, back door tax collectors . . . hospital and physician billing offices . . . who do their best to recoup these uncompensated costs from their paying customers, chiefly businesses sponsoring health benefit plans.

The public sector is not alone in shifting costs to businesses offering health coverage. Some private sector employers are doing the same thing. Clearly, for example, a disproportionate share of employer paid health costs is borne by the manufacturing sector of the economy to the benefit of the service sector. Consider the fact that 49% of those employed in retail firms (excluding eating and drinking places) are

either uninsured or insured elsewhere (usually by the employer of their employee's spouse or parent). For eating and drinking establishments the comparable figure is 76%! As a result of this phenomenon, rather than using the opportunity to spread part of the cost of financing health care delivery to American citizens by adding to the cost of every hamburger, beer or necktie sold in this country, where none of the sellers are threatened by foreign competitors, we instead add to the costs and prices of U.S. manufacturers who do face serious competition from abroad.

The status quo cries out for a solution. We submit that, acting effectively in its various capacities as the sponsor of public health programs, as a standard setter and as the developer of tax policy, the Federal Government can and must help chart the course for a rational health policy for America. It can fulfill this role in one of two general ways—either by establishing the overall ground rules within which a public/private partnership can work to achieve our nation's health care objectives, or by establishing a fully publicly financed and administered plan. We do not see any other solutions at this time which hold promise for success.

Whichever alternative is ultimately chosen (and depending on the specific details of the policy, Chrysler could support either strategy), the policy must be capable of responding to both the patient care and fiscal needs of this country. Specifically, our objectives should be a health system within which the necessary health care needs of all citizens are met; a system which consumes resources prudently, balances spending on health with other national priorities, spreads costs over the broadest possible base and does not disproportionately impact any segment of the economy; and a system which exists in a context of continuous quality improvement.

Further, to accomplish these objectives the policy must embody certain key principles:

EQUITY AMONG PAYERS

This obviously is only an issue were we to have a public/private partnership. Clearly, public coverage must be available for all the poor. Further, given the government as a "partner," this requires a process for the determination of fair provider fees, with such fees applicable to all public and private sector payers. There should be no room for cost shifting from the public to the private sector other than through the valid process of appropriating tax revenues to fund public programs.

EQUITY WITHIN THE ECONOMY

If we are to rely on employer financing in the future, all employers must participate. This can be done without harming weak or deterring start-up enterprises and without encumbering established employers with unreasonable costs and FASB liabilities. To help accomplish this within a public/private reform strategy, any employer or individual should have the option to pay a tax no greater than the cost of a community rated premium, thus permitting enrollment in a publicly administered health plan. This will help assure costs are spread across the broadest possible base in our economy and that no sector of the economy or no employer bears a disproportionately large share of expenditures.

FISCAL INTEGRITY

No nation on earth has embarked on a program to provide all citizens access to health care without concurrently adopting a strategy to control aggregate national health care spending. Such management of spending should extend not only to spending for health services, but spending for capital items and graduate medical education as well. This is critical.

Finally, in shaping a health system for the 21st century, America should strive to become the best. We should not feel compelled to adopt any other nation's health system, lock, stock and barrel. Many nations, including Canada and Germany, believe they are spending too for health care and are looking to build on their systems by adopting some of the good elements of the U.S. system. We should do the same. For example, Canada is exploring the use of organized health care delivery systems; *but there is no consideration being given by Canada to dismantling its controls over overall system costs and the cost of capital items.*

A major problem the health system reform debate must contend with is how to address the legitimate concerns of the very small business person. Seventy-five percent of U.S. businesses employ fewer than ten persons. The majority of them do not currently offer health coverage. They represent an obstacle to universal access *if* employer-based coverage is to be the chosen financing vehicle. If the concerns of these employers cannot be satisfied because of worries about tying health coverage in any way to employment and the resulting impact on hiring and production costs,

and as a result the health system reform needed by employers currently offering coverage is stalemated, then we believe it would be appropriate to reconsider the tie to employment and move to a fully publicly financed system.

Further, while much attention has been given to the concerns of small businesses, similar attention should be accorded the problems of mature companies. Many such firms have been in business well over 50 years, were extraordinarily labor intensive (and still are to a lesser extent), and now have many retirees and older workforces reflecting a combination of the firms' years of existence, continued automation and foreign competition. With the U.S. increasingly battling in a global economy, we must revisit rules applicable to U.S. firms which differ from rules applicable to our major trading partners. For example, rules or practices relating to the way employers help finance the provision of health care to employees and to pre-age 65 retirees, and the way businesses must account for such costs. By focusing all our attention on small businesses we run the risk of becoming a nation of start-up companies, which gradually over time lose their markets to foreign producers.

There have been other road blocks to reform. Some approach myth status. For example, often we read "managed care" is businesses' last hope before "national health insurance." What is amusing about this myth is that it assumes "managed care" and "national health insurance" are mutually exclusive terms. They are not. The manner in which a society chooses to deliver health services to citizens and the manner that same society chooses to finance the delivery of care are distinct issues. Clearly, "managed care" is a valid cost control strategy and should be encouraged. Medicare today, for example, could be 100% managed care. We must not, however, let "managed care" become the "Voluntary Effort" of the 90s and stifle the systemic changes that are necessary.

Another issue currently in vogue is insurance reform, chiefly with respect to small businesses. Insurance reform is essentially an insurance policy holder payment equity issue. Huge penalties currently paid by many small policy holders will simply get spread among other policy holders. It promises little, if anything, to control aggregate U.S. health costs or improve the plight of the uninsured. It is not a bad idea; but we must not delude ourselves it is a panacea.

A final myth, a classic red herring exploited by some in the provider community, is that any control over aggregate spending will cause citizens to stand in line for services as health care is rationed.

First, we should never fear rationing excess; instead we should seek to eliminate it. More fundamentally, however, a "budget" does not necessarily imply deprivation. It is simply a function of how much a society chooses to spend on health or anything else. If you have a large enough budget, you can get instant gratification. The key is to create a process where citizens can choose where they want to spend their resources. The alternative to a budget is to have no control on spending. This is unacceptable and yet this is what we have today.

In short, the status quo makes no sense and the problem is not going to be fully solved by everyone doing their best to live good, healthy lives. Nor is it going to be fully solved by acts of charity. We need to go further and enact the fundamental policy initiatives reflected above. To accomplish this objective, however, an informed public is essential; a public convinced that it is in everyone's interest, not just the poor or the employed-uninsured, to have fundamental health system reform.

Today, citizens are clearly not aware of the growing costs they continue to bear as a result of *inaction*. Barring change, health costs will exceed $2 trillion by the year 2000 and will absorb over 20% of our nation's GNP. Health costs are growing far faster than family income, than business income, then local, state or Federal Government income (i.e., tax receipts). The result: a steady reduction in citizens' standard of living as health care absorbs more and more of our citizens' and our nation's resources and saps the strength of its businesses. This is happening without a vote of the people because our nation lacks a health policy, lacks a system to address the problem. This is the result of inaction.

The sooner our society rises to this challenge, the sooner it will be able to enjoy the fruits of redeploying the hundreds of billions of dollars excessively squandered on our nation's health system so that those resources can be used to benefit and strengthen all citizens and our economy in general.

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

Mr. Chairman, I appreciate the opportunity to express my concern about the lack of access to health care for all Americans and the need to reform the health care system to both expand access and to control the rapidly escalating costs of health

care in our society. I commend you for holding this hearing today and for your long commitment to this vital issue.

Access to affordable, quality health care should be a right for all Americans. While we have the best health care technology in the world, but we have not yet worked out how to make it reach every one of our citizens. The cost of health care and the rapidly changing demographics of our society shape the challenge of health care reform.

One third of those without health insurance coverage are children. If we ignore the health care of our children now, it will cost us more to deal with the effects later. We must assure all American children access to quality health care if they are to be ready to learn and develop into productive adults.

We must also address the unmet health care needs of the nation's elderly. The fastest growing group in our nation in percentage terms are those persons over the age of eighty-five. While we must work to provide access to health care for children and adults, the nation must also address the serious gap in health care coverage for the elderly—the need for long-term care.

Health care reform must involve both efforts to provide for the uninsured, as well as fundamental reform of the health care system to include cost containment efforts and insurance market reform.

It is critical that the states and Federal Government work together toward health care reform. Many of the states, including Maine, have been innovators in health care reform. Congress should look to the states to determine whether some of those innovative programs might be appropriately expandedon a national level.

Health policy in the United States for the past decade has been driven primarily by cost considerations. But cost cutting alone does not constitute health policy. We as a nation need to make explicit decisions about what we want to pay for.

I believe that we can get more value for the over six hundred billion dollars we spend each year on health care. We face difficult challenges in the light of the overwhelming budget deficit. However, we must continue to look for solutions—a failure to do so could result in the ultimate collapse of this nation's health care system.

I believe we must build upon the existing public—private partnership which asks employers to share the responsibility of providing access to health care for their employees and their dependents.

Currently that burden is not shared equitably by all employers. A significant number of large businesses are now actively promoting health care reform. Large companies like Chrysler and other major corporations provide a disproportionate share of health care coverage in the business community.

While it is difficult for small businesses to provide health coverage to their employees and their dependents, most already do so. Health Insurance coverage is offered by 80% of businesses with 25 or fewer employees; coverage is offered in 46% of businesses with 10 or fewer employees.

Unfortunately it has become more difficult and more expensive for small business to cover their employees. If we are going to expect small business to provide health coverage to their employees, we must make it more affordable to do so.

We must have reform in the small group insurance market. We must stop the practice of "churning"—where small businesses are changing health care plans each year in a desperate search for more affordable coverage.

We must significantly reduce medical underwriting in the small group market so that the illness of one employee does not prohibit the employee or the entire group from purchasing insurance.

We must make health care insurance plans more affordable. Health care reform must include significant and meaningful cost containment strategies.

The Federal and State governments must share the burden in reforming the health care system. Even under the best case scenario, not all Americans will have access to employer-based health insurance.

We must reform and expand the public system. This may ultimately result in a significant reform of the Medicaid program—or the development of a new program.

While we must work to provide access to health care for children and adults under age 65, the nation must also address the serious gap in health care coverage to the elderly—the need for long term care.

At the turn of the century, one in twenty-five Americans was over the age of sixty-five. Today one in eight Americans has reached that age. The fastest growing group in our nation in percentage terms is the over-age eighty-five group.

Fortunately, medical advances have enabled us to live longer and adapt to greater levels of disability during our lifetime.

The largest portion of health care is consumed during the closing years of life—the implications for the American health care system are clear: A greater demand than ever before for acute and chronic care.

We must continue to work toward a viable long term care policy which will provide care to the elderly based on their health care needs, rather than which services are reimburseable.

The elderly whose families cannot care for them privately have spent themselves into poverty and now consume, for long-term care needs, almost half of the nation's total Medicaid budget—ironically, the very program that was intended to help extend care to the poor.

In spite of our experience with the Catastrophic Health legislation, we must continue to search for viable financing mechanisms for long term care.

The interaction of these problems, of working persons and children without coverage and elderly persons without coverage for the most costly form of care, illustrates the kind of dilemma that a society faces when there is no long-range public policy.

Consumers too, must play a part—consumer demand is part of the cost problem too.

We must decide whether an investment in preventive health care now will save money in the future. I believe that we must invest in prenatal care and childhood immunizations.

The Congress must begin to focus on comprehensive reform of the health care system. We must look beyond the immediate crisis of budget cuts in health care programs toward restructuring our health care system in a way which will provide services to all who need them while controlling the rapidly escalating costs of health care.

We must give time and thought to the long-term policy goals that we want to see for American health. If we do not, we risk seeing our health policies lurch from emergency to crisis, decade after decade, while the best health care system in the world fails to reach every one of the people for whose benefit it was developed.

These are difficult challenges in the light of the overwhelming budget deficit. However, we must continue to look for solutions—a failure to do so could result in the ultimate collapse of this nation's health care system. The solution to these problems are among my highest priorities this year.

SUBMITTED BY SENATOR DONALD W. RIEGLE, JR.

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-241836

February 8, 1991

The Honorable Donald W. Riegle, Jr.
Chairman, Subcommittee on Health for
Families and the Uninsured
Committee on Finance
United States Senate

Dear Mr. Chairman:

This fact sheet responds to your request for profiles of individuals without health insurance.[1] It presents income, employment, age, marital status, and other characteristics of the uninsured populations in various states and the United States as a whole in 1988. We used the Bureau of the Census' March 1989 Current Population Survey for our analysis and selected states where the survey sample size was expected to be large enough to provide usable results. The 15 states we selected are Alabama, California, Florida, Georgia, Illinois, Louisiana, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Virginia.

Background

For most of the 1980s, estimates show that more than 30 million Americans were not covered by health insurance, one of the most important channels of access to our health care system. These estimates suggest that gaps remain in the health insurance coverage of our nation's citizens despite the almost total coverage of the elderly through Medicare, the expansions in Medicaid coverage, and the large percentage of the population with private insurance protection provided through employer- or union-sponsored health plans. Although employer-provided plans are the primary source of health insurance, most of the uninsured are employed.

Results in Brief

In 1988, about 32 million Americans (under age 65),[2] or 15 percent of this population, did not have some form of health insurance coverage. Although uninsured rates varied among the states, the uninsured populations in the 15 states we evaluated had many of the same demographic characteristics as the nationwide uninsured population. The uninsured

[1]Health insurance coverage is based on individual self-reporting of health insurance status in 1988 from the Bureau of the Census' March 1989 Current Population Survey.

[2]Because about 99 percent of individuals 65 and older had Medicare or private insurance, we excluded this group from our study.

tended to be concentrated among the lower income, minority, youth, unmarried, and less educated segments of the population.

Of particular significance was that a large majority of the uninsured were employed. Part-time/part-year workers represented the highest percentage of uninsured workers in most of the states we examined. However, full-time workers also make up a substantial share of the uninsured population in most of these states. In terms of industry categories, the uninsured rates for workers in service industries (such as wholesale and retail trade, real estate, and entertainment) for the most part, were higher than those in manufacturing industries (such as motor vehicles and textile and chemical products).

Objectives, Scope, and Methodology

We agreed to focus on identifying and comparing the characteristics of uninsured people in various states and the United States in 1988 using the Bureau of the Census' 1989 Current Population Survey. These data became available in early 1990 (see app. I for a description of the survey).

The Census survey was not designed specifically to capture representative samples of state uninsured populations. We selected states where the survey sample size was expected to be large enough to provide usable results. Even in some of the states we selected, large sampling errors for selected data items suggest that users of these data should exercise caution. About 65 percent of the nation's uninsured population resided in the 15 selected states (see table II.1, p. 12). The sampling errors associated with estimates of uninsured populations stated at the 95-percent confidence level, are presented in appendix VIII.

GAO's Analysis

Uninsured Rates Varied Widely Among the States in 1988

While 15 percent of the U.S. population under age 65 was uninsured in 1988, there was considerable variation in uninsured rates among the 50 states and the District of Columbia. Uninsured rates among all the states ranged from 8 percent in Michigan and Rhode Island to 26 percent in New Mexico and Texas. The higher rates tended to occur in the West South Central section of the United States, and the lower in the upper Midwest and Northeast sections (see fig. II.1 and table II.2, pp. 13 and 14).

Employment-Based Health Insurance Most Common

In 1988, most of the population had health insurance that was provided through employers or unions. Variation in rates of health insurance coverage among states were associated with the level of employment-based insurance provided (see tables III.1-III.16, pp. 16-24). States with higher rates of employer-based private insurance coverage—like Illinois, Michigan, New Jersey, Ohio, and Pennsylvania—tended to have a lower proportion of their populations without health insurance.

Coverage by the federally sponsored Medicaid program varied considerably in the 15 states. Nationally, about 7 percent of the under-age-65 population was covered by Medicaid, while the rate of coverage varied between 4 percent in New Jersey and 12 percent in Louisiana (see tables III.1-III.16, pp. 16-24).

Uninsured Rates Higher in Service and Other Nonmanufacturing Industries

Generally, the percentages of uninsured workers in the service sector of the economy and other industries (such as agriculture, mining, construction, public utilities, and transportation) continued to be higher than those in the manufacturing sector. In 1988, the service and other industries had a 16-percent and 21-percent uninsured rate, respectively, compared to an 11-percent rate for the manufacturing sector. In 12 of the 15 selected states,[3] manufacturing had the lowest rates of the three major industry categories (see fig. IV.1 and table IV.1, pp. 25 and 26). Uninsured rates varied considerably among individual industries within and between states.

Income an Important Indicator of Insurance Status

People in families with low incomes are more likely to be without health insurance. Nationally, 34 percent of persons in families with incomes below the poverty level were without health insurance (see fig. V.1, p. 28). Uninsured rates, however, varied widely among the states. Among the 15 selected states, the percentages of people in families with incomes below the poverty level that were uninsured ranged from 17 percent in New York to 58 percent in Texas. The uninsured rate for people in families below the poverty level exceeded 25 percent in 11 of the 15 states (see table V.1, p. 29).

Most of the uninsured were in families with incomes less than twice the poverty level in the United States (see fig. V.2, p. 31). However, lack of health insurance coverage was not restricted to the low-income population. While more than half of uninsured workers in the United States

[3]In five of these states, the differences are statistically significant at the 95-percent confidence level.

had less than $20,000 income in 1988, 46 percent of uninsured workers had incomes of $20,000 or more. Fifteen percent of uninsured workers had income of $40,000 or more (see fig. V.3 and table V.2, pp. 31 and 32).

The Unemployed Have Higher Uninsured Rates, but Most Uninsured Are Employed

Unemployed people had the highest uninsured rate (50 percent) among the employment status groups of people aged 19-64 nationwide. In states with sufficient data to measure the uninsured rate by employment status, the unemployed generally had the highest uninsured rates ranging from 31 percent in Louisiana to 68 percent in Texas (see fig. VI.1 and table VI.1, pp. 34 and 35).

However, attachment to the labor force is no guarantee of health insurance coverage. Many employed people also were without health insurance. In each of the 15 states, most of the uninsured were employed. Particularly hard hit were workers with part-time or part-year jobs. Workers with full-time jobs, however, were not immune to the problem. Over a third of all uninsured aged 19-64 had full-time jobs in 1988 (see fig. VI.2 and table VI.2, pp. 36 and 37).

Young Adults, Minorities, the Unmarried, and Less Educated More Likely to Be Uninsured

The likelihood of being uninsured in the United States is greater among young adults, minorities, unmarried people, and those with less than a high school education. Likewise, in most of the 15 selected states the uninsured rates were highest for people who were aged 19-24, were either black or Hispanic, were separated or divorced, and had no more than a grade school education (see tables VII.1-VII.5 and figs. VII.1-VII.5, pp. 38-48).

Minorities make up a disproportionate segment of the uninsured. In 1988, 33 percent of Hispanics and 21 percent of blacks were uninsured compared to 12 percent of whites. In each of the 15 states, the uninsured rates for blacks exceeded that for whites.[4] In states that have a substantial Hispanic population (California and Texas), uninsured rates within the Hispanic population were the highest among the racial/ethnic groups. In California, for example, 35 percent of Hispanics were uninsured compared to 13 percent of whites and 15 percent of blacks (see tables VII.2 and VII.3, pp. 41 and 43).

[4]In 9 of these states, the differences are statistically significant at the 95-percent confidence level.

Although the uninsured rates for minorities are high, the white population still makes up the majority of the uninsured population. In fact, in 12 of the 15 states (all except California, Georgia, and Texas), more than half of the uninsured populations were white.

As requested by your staff, we did not obtain agency comments on this fact sheet. We are sending copies of this report to the Secretary of Health and Human Services and the 15 states selected for analysis. We will also make copies available to others on request.

If you or your staff have any questions concerning this fact sheet, please contact me on (202) 275-6195. Other major contributors are listed in appendix IX.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director for National and
Public Health Issues

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Figures

Abbreviations

CHAMPUS Civilian Health and Medical Program of the Uniformed Services
CPS Current Population Survey

Appendix I

Current Population Survey

The Bureau of the Census' Current Population Survey (CPS) is the source of most official government statistics on employment and unemployment. For the survey, households are scientifically selected on the basis of area of residence to represent the nation as a whole, individual states, and other specified areas. The sample used in the March 1989 survey consists of about 56,500 households. The universe is the civilian noninstitutional population of the United States and members of the Armed Forces living with their families in civilian housing units or on a military base. A probability sample is used in selecting housing units. Each household is interviewed once a month for 4 consecutive months during a 1-year period, and again for the corresponding time period a year later. This technique enables Census to obtain month-to-month and year-to-year comparisons at reasonable cost.

CPS also provides monthly labor force data, including supplemental data on work experience, income, noncash benefits, and migration. Comprehensive information is collected on the employment status, occupation, and industry in which individuals work. Additional data are available on the number of weeks and hours per week worked by individuals and their total income. Although the main purpose of the survey is to collect data on the employment situation, the secondary purpose, also important, is to gather information on the demographic status of the population. This includes age, sex, race, marital status, educational attainment, and family structure. The results serve to update similar information collected through the decennial census. Government policymakers and legislators use the data as indicators of our nation's economic situation and to plan and evaluate many government programs.

In addition, the survey provides current estimates of the economic status and activities of the nation's population. Because it is not possible to develop one or two overall figures (such as the number of unemployed) that would adequately describe the whole labor market, the survey is designed to provide a large amount of detailed and supplementary data. Such data are made available to users of labor market information to meet various needs.

The survey provides the only data available on the distribution of workers by number of hours worked for the population as a whole (as distinguished from aggregate or average hours for an industry). This permits separate analyses of part-time workers, workers on overtime, and other groups. Also, the survey is the only comprehensive, current source of information on the occupation of workers and the industries in

which they work. Information is available not only for people currently in the labor force, but also for those outside it.

In March of every year, Census asks questions about health insurance coverage at any time during the previous year. Beginning in March 1988, Census implemented a major change in its health insurance questions. In previous surveys, Census determined private health insurance coverage for dependents through questions focused on policyholders (e.g., who else was covered by this policy or plan?). Under its new procedures, Census supplemented these questions by focusing questions on overall health insurance coverage to better gain information about the health insurance status of each household member. According to Census, the decline in the estimate of the uninsured population can almost certainly be attributed to the questionnaire modifications on the March 1988 CPS.

CPS was not designed to capture representative samples of state uninsured populations that would enable users to make refined estimates of some characteristics of the uninsured. Because of the many variables we analyzed on the 15 states' uninsured population, users of this report should exercise caution when interpreting these data because sampling errors would vary depending on the sufficiency of the population base. Sampling errors for the data elements in this report were computed at the 95-percent confidence level (see app. VIII).

Appendix II

Uninsured Populations in the United States

This appendix shows the number and percentage of uninsured people by state, region, and division. Figure II.1 depicts rate groupings in different geographic areas of the United States. Table II.1 lists the 15 states with the highest numbers and rates of uninsured people. Table II.2 gives uninsured rates by state categorized by region and division.

Table II.1: Fifteen States With Highest Numbers and Rates of Uninsured Under Age 65 (1988)

State	Number of uninsured (thousands)	Uninsured as a percentage of state population
Highest numbers of uninsured		
California	4,937	20
Texas	3,946	26
Florida	2,208	21
New York	1,855	12
Illinois	1,141	11
Georgia	993	18
Louisiana	963	25
Ohio	943	10
Pennsylvania	921	9
North Carolina	787	14
Alabama	675	19
Virginia	671	13
New Jersey	658	10
Michigan	646	8
Tennessee	644	15
Highest rates of uninsured		
New Mexico	351	26
Texas	3,946	26
Louisiana	963	25
Nevada	225	23
Oklahoma	621	23
Arkansas	467	22
Mississippi	491	22
Florida	2,208	21
Arizona	618	20
California	4,937	20
Alabama	675	19
District of Columbia	95	19
Alaska	84	19
Georgia	993	18
Kentucky	559	18

Figure II.1: Uninsured by Percentage of State Populations (1988)

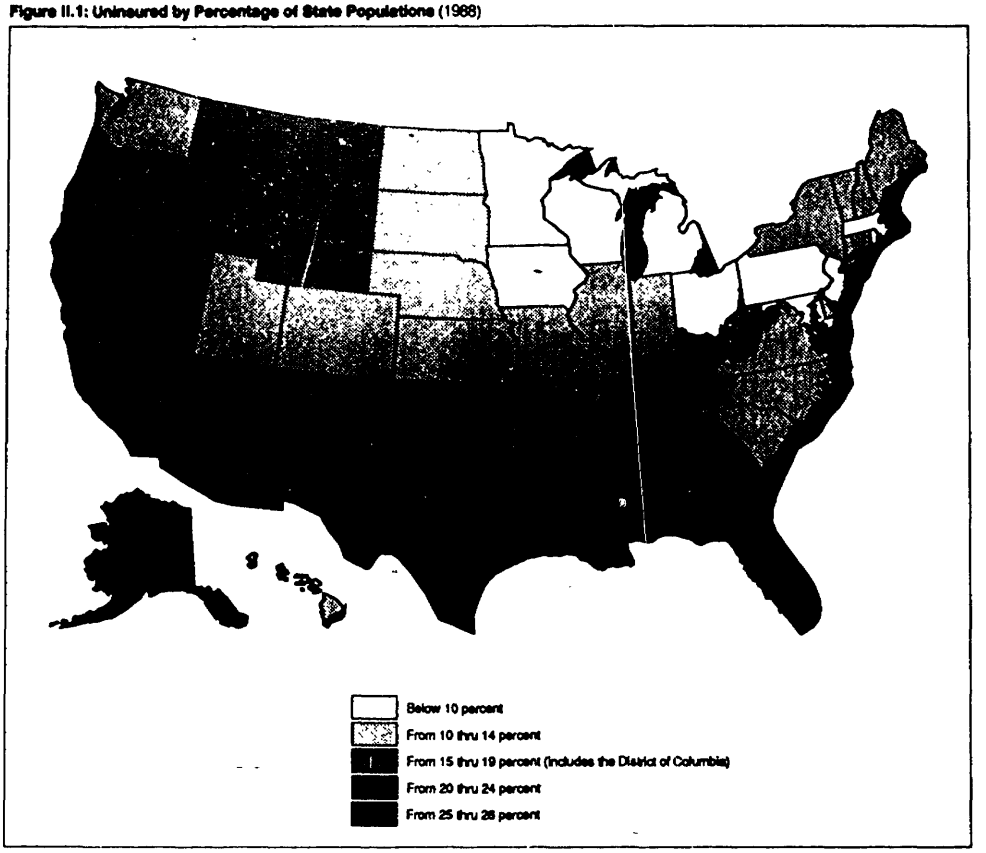

Table II.2: Uninsured Populations by Region, Division, and State (1988)[a]

Region/division/state	Number of uninsured (thousands)	Uninsured as a percentage of state population
Northeast Region		
New England:		
Connecticut	282	10
Maine	112	11
Massachusetts	485	9
New Hampshire	120	12
Rhode Island	68	8
Vermont	57	12
Middle Atlantic:		
New Jersey	658	10
New York	1,855	12
Pennsylvania	921	9
Midwest Region		
East North Central:		
Illinois	1,141	11
Indiana	600	12
Michigan	646	8
Ohio	943	10
Wisconsin	388	9
West North Central:		
Iowa	211	9
Kansas	215	10
Minnesota	382	10
Missouri	591	13
Nebraska	161	12
North Dakota	60	10
South Dakota	91	15
West Region		
Mountain:		
Arizona	618	20
Colorado	410	15
Idaho	150	17
Montana	116	17
Nevada	225	23
New Mexico	351	26
Utah	196	13
Wyoming	63	15

(continued)

Region/division/state	Number of uninsured (thousands)	Uninsured as a percentage of state population
Pacific:		
Alaska	84	19
California	4,937	20
Hawaii	103	11
Oregon	402	17
Washington	480	12
South Region		
East South Central:		
Alabama	675	19
Kentucky	559	18
Mississippi	491	22
Tennessee	644	15
West South Central:		
Arkansas	467	22
Louisiana	963	25
Oklahoma	621	23
Texas	3,946	26
South Atlantic:		
Delaware	60	10
District of Columbia	95	19
Florida	2,208	21
Georgia	993	18
Maryland	410	10
North Carolina	787	14
South Carolina	437	15
Virginia	671	13
West Virginia	255	16

[a]The data include only people under age 65.

Appendix III

Health Insurance Coverage of Populations

This appendix contains information on the health insurance coverage of individuals under age 65 in the United States and 15 states. It shows the estimated numbers and percentages for uninsured people and also for individuals with health insurance coverage provided through private insurance and public programs, such as Medicaid and Medicare.

Table III.1: Health Insurance Coverage of Individuals Under Age 65 in the United States (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	141,769	66
Individual-provided	17,615	8
Public		
Medicaid	15,312	7
Medicare	2,400	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	5,163	2
Subtotal	**182,259**	**84**
No insurance coverage	32,405	15
Total	**214,663[c]**	**100[c]**

[a]The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing

[c]Figures do not add due to rounding

Table III.2: Health Insurance Coverage of Individuals Under Age 65 in Alabama (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	2,203	63
Individual-provided	219	6
Public		
Medicaid	275	8
Medicare	59	2
CHAMPUS,[a] Veterans Affairs, Military Health[b]	48	1
Subtotal	**2,804**	**80**
No insurance coverage	675	19
Total	**3,478[c]**	**100[c]**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.3: Health Insurance Coverage of Individuals Under Age 65 in California (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	14,758	59
Individual-provided	1,904	8
Public		
Medicaid	2,429	10
Medicare	249	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	632	3
Subtotal	**19,972**	**81**
No insurance coverage	4,937	20
Total	**24,910[c]**	**100[c]**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.4: Health Insurance Coverage of Individuals Under Age 65 in Florida (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	6,104	59
Individual-provided	1,026	10
Public		
Medicaid	538	5
Medicare	135	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	408	4
Subtotal	**8,211**	**79**
No insurance coverage	2,208	21
Total	**10,420**[c]	**100**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.5: Health Insurance Coverage of Individuals Under Age 65 in Georgia (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	3,527	63
Individual-provided	451	8
Public		
Medicaid	339	6
Medicare	96	2
CHAMPUS,[a] Veterans Affairs, Military Health[b]	158	3
Subtotal	**4,571**	**82**
No insurance coverage	993	18
Total	**5,564**	**100**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

Table III.6: Health Insurance Coverage of Individuals Under Age 65 in Illinois (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	7,147	71
Individual-provided	773	8
Public		
Medicaid	831	8
Medicare	118	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	84	1
Subtotal	**8,953**	**89**
No insurance coverage	1,141	11
Total	**10,094**	**100**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

Table III.7: Health Insurance Coverage of Individuals Under Age 65 in Louisiana (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	1,938	50
Individual-provided	305	8
Public		
Medicaid	474	12
Medicare	48	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	118	3
Subtotal	**2,883**	**74**
No insurance coverage	963	25
Total	**3,847[c]**	**100[c]**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.8: Health Insurance Coverage of Individuals Under Age 65 in Michigan (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	5,952	73
Individual-provided	627	8
Public		
Medicaid	790	10
Medicare	107	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	83	1
Subtotal	**7,559**	**93**
No insurance coverage	646	8
Total	**8,205**	**100[c]**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.9: Health Insurance Coverage of Individuals Under Age 65 in New Jersey (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	5,030	76
Individual-provided	547	8
Public		
Medicaid	292	4
Medicare	58	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	48	1
Subtotal	**5,975**	**90**
No insurance coverage	658	10
Total	**6,633**	**100**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

Table III.10: Health Insurance Coverage of Individuals Under Age 65 in New York (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	10,375	68
Individual-provided	1,059	7
Public		
Medicaid	1,656	11
Medicare	241	2
CHAMPUS,[a] Veterans Affairs, Military Health[b]	182	1
Subtotal	**13,513**	**89**
No insurance coverage	1,855	12
Total	**15,367[c]**	**100[c]**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.11: Health Insurance Coverage of Individuals Under Age 65 in North Carolina (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	3,819	69
Individual-provided	460	8
Public		
Medicaid	231	4
Medicare	91	2
CHAMPUS,[a] Veterans Affairs, Military Health[b]	186	3
Subtotal	**4,789**	**86**
No insurance coverage	787	14
Total	**5,576**	**100**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

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Table III.12: Health Insurance Coverage of Individuals Under Age 65 in Ohio (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	7,130	73
Individual-provided	638	7
Public		
Medicaid	817	8
Medicare	110	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	77	1
Subtotal	**8,772**	**90**
No insurance coverage	943	10
Total	**9,717[c]**	**100[c]**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.13: Health Insurance Coverage of Individuals Under Age 65 in Pennsylvania (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	7,752	75
Individual-provided	793	8
Public		
Medicaid	661	6
Medicare	132	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	147	1
Subtotal	**9,486**	**91**
No insurance coverage	921	9
Total	**10,408[c]**	**100**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.14: Health Insurance Coverage of Individuals Under Age 65 in Tennessee (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	2,699	63
Individual-provided	405	9
Public		
Medicaid	422	10
Medicare	79	2
CHAMPUS,[a] Veterans Affairs, Military Health[b]	53	1
Subtotal	**3,658**	**85**
No insurance coverage	644	15
Total	**4,303[c]**	**100**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.15: Health Insurance Coverage of Individuals Under Age 65 in Texas (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	8,668	57
Individual-provided	1,150	8
Public		
Medicaid	830	6
Medicare	106	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	520	3
Subtotal	**11,274**	**75**
No insurance coverage	3,946	26
Total	**15,221[c]**	**100[c]**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

[c]Figures do not add due to rounding.

Table III.1(i): Health Insurance Coverage of Individuals Under Age 65 in Virginia (1988)

Type of insurance	Number (thousands)	Percent
Private		
Employer- or union-provided	3,545	67
Individual-provided	413	8
Public		
Medicaid	265	5
Medicare	64	1
CHAMPUS,[a] Veterans Affairs, Military Health[b]	355	7
Subtotal	**4,642**	**88**
No insurance coverage	671	13
Total	**5,312[c]**	**100[c]**

[a]CHAMPUS is operated by the Department of Defense. The program provides reimbursement for covered medical care rendered in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel.

[b]Members of the Armed Forces and their dependents living in off-base housing or on-base military housing.

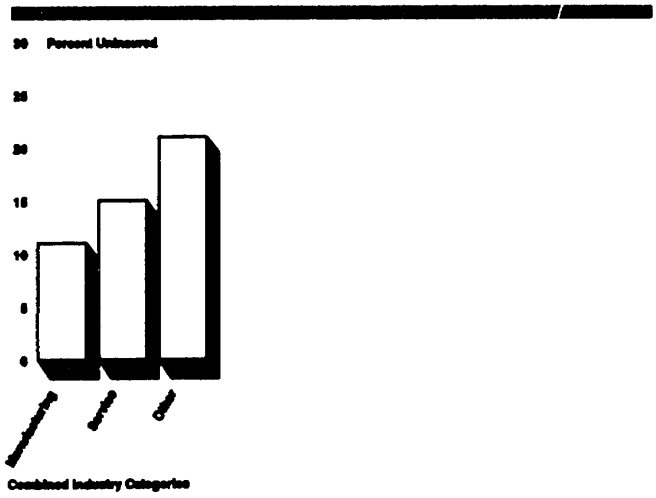
[c]Figures do not add due to rounding.

Appendix IV

Uninsured Rates for Workers by Industry Group

This appendix shows uninsured rates in employment sectors of the economy for the United States and 15 states. Individual industries are combined into three categories—manufacturing (e.g., durable and nondurable goods); services (e.g., wholesale and retail trade, insurance, real estate, entertainment, and recreation); and other (e.g., agriculture, fisheries, construction, and public utilities).

Figure IV.1: Uninsured Rate in the United States is Lower in Manufacturing Than in Service and Other Industries (1988)



Notes. Based on individuals aged 19-64 who responded to industry-related questions.

Manufacturing industries include durable goods (such as motor vehicles and equipment) and nondurable goods (such as textile and chemical products) industries

Service industries include wholesale trade, retail trade; finance, insurance, and real estate, business and repair services, personal services, entertainment and recreation services; professional and related services, and public administration.

Other industries include agriculture, forestry, and fisheries; mining; construction, and transportation, communications, and other public utilities

Source Bureau of the Census, CPS (Washington, D C , 1988).

Table IV.1: Uninsured Rates in Most of the 15 States Are Lower in Manufacturing Than in Service and Other Industries (1988)[a]

Employment figures in thousands

	Combined industry categories			
	Manufacturing[b]	Services[c]	Other[d]	Total
Alabama				
Employment	487	1,058	279	1,824
Percentage of workers uninsured	16	20	25	20
California				
Employment	2,519	9,109	2,217	13,845
Percentage of workers uninsured	19	20	24	20
Florida				
Employment	707	4,055	1,155	5,917
Percentage of workers uninsured	16	18	31	20
Georgia				
Employment	716	1,859	558	3,131[e]
Percentage of workers uninsured	17	18	24	19
Illinois				
Employment	1,128	3,563	876	5,567
Percentage of workers uninsured	8	13	13	12
Louisiana				
Employment	199	1,240	392	1,832[e]
Percentage of workers uninsured	24	22	34	25
Michigan				
Employment	1,105	2,790	559	4,454
Percentage of workers uninsured	6	10	14	9
New Jersey				
Employment	805	2,467	651	3,923
Percentage of workers uninsured	9	10	13	10
New York				
Employment	1,335	5,731	1,267	8,334[e]
Percentage of workers uninsured	12	12	18	13
North Carolina				
Employment	927	1,849	533	3,309
Percentage of workers uninsured	9	13	21	13
Ohio				
Employment	1,258	3,217	772	5,247
Percentage of workers uninsured	4	12	15	11
Pennsylvania				
Employment	1,225	3,697	894	5,815[e]
Percentage of workers uninsured	6	10	10	9

(continued)

	Combined industry categories			
	Manufacturing[b]	Services[c]	Other[d]	Total
Tennessee				
Employment	606	1,273	444	2,323
Percentage of workers uninsured	8	15	16	13
Texas				
Employment	1,191	5,136	1,648	7,976[e]
Percentage of workers uninsured	18	23	33	24
Virginia				
Employment	425	2,042	507	2,974
Percentage of workers uninsured	13	11	22	13
United States				
Employment	22,543	76,471	20,475	119,489
Percentage of workers uninsured	11	15	21	15

[a]The data are based on individuals aged 19-64 who responded to employment industry-related questions

[b]Manufacturing includes durable goods (such as motor vehicles and equipment) and nondurable goods (such as textile and chemical products) industries.

[c]Service industries include wholesale trade; retail trade; finance, insurance, and real estate; business and repair services; personal services; entertainment and recreation services, professional and related services; and public administration.

[d]Other industries include agriculture, forestry, and fisheries; mining; construction; and transportation, communications, and other public utilities.

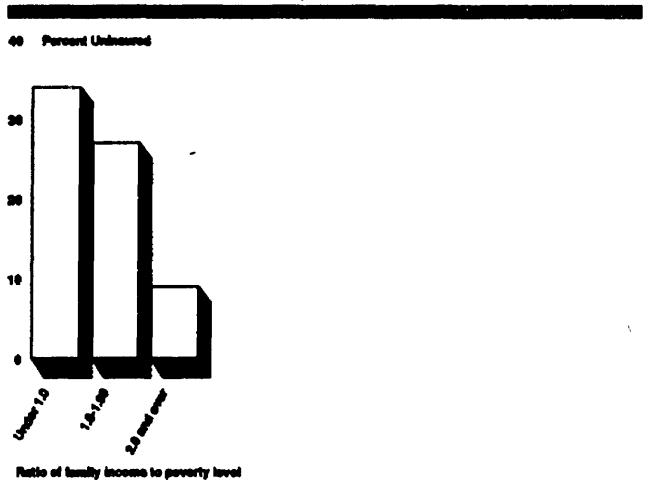
[e]Numbers do not add to total due to rounding

Appendix V

Uninsured Rates by Income Status

This appendix shows uninsured rates by income class for the United States and the 15 states. Income data are presented in terms of poverty status and income level. Figures V.1 and V.2 and table V.1 give uninsured rates in relation to the ratio of family income to the federal poverty level. Some proposals to extend coverage to individuals are defined in terms of poverty level. For example, the Pepper Commission report on comprehensive health care recommends that public health care subsidies be available to families with incomes below two times the federal poverty level. Table V.2 provides another perspective showing the relation between dollar income and health insurance status for the working population by full-time and part-time employment status.

Figure V.1: A High Percentage of Low-Income Families in the United States Is Uninsured (1988)



Note Includes only people under age 65. Percentage of uninsured within poverty level ranges in the United States is shown in table V 1

Source Bureau of the Census, CPS (Washington, D C , 1988)

Table V.1: Low-Income Families Have Higher Uninsured Rates in the 15 States (1986)[a]

Numbers are in thousands unless otherwise noted

	Ratio of family income to poverty level			
	Under 1.0	1.0-1.99	2.0 and over	Total
Alabama				
Population in income class	675	834	1,969	3,478
Uninsured	306	236	131	675
Percent of income class uninsured	**45**	**28**	**7**	**19**
California				
Population in income class	3,498	4,419	16,992	24,910[b]
Uninsured	1,235	1,569	2,133	4,937
Percent of income class uninsured	**35**	**36**	**13**	**20**
Florida				
Population in income class	1,433	1,979	7,009	10,420[b]
Uninsured	678	715	814	2,208
Percent of income class uninsured	**47**	**36**	**12**	**21**
Georgia				
Population in income class	781	1,060	3,723	5,564
Uninsured	299	312	382	993
Percent of income class uninsured	**38**	**30**	**10**	**18**
Illinois				
Population in income class	1,293	1,498	7,306	10,094[b]
Uninsured	344	357	440	1,141
Percent of income class uninsured	**27**	**24**	**6**	**11**
Louisiana				
Population in income class	883	872	2,092	3,847
Uninsured	327	353	283	963
Percent of income class uninsured	**37**	**41**	**14**	**25**
Michigan				
Population in income class	1,042	1,223	5,940	8,205
Uninsured	210	173	263	646
Percent of income class uninsured	**20**	**14**	**4**	**8**
New Jersey				
Population in income class	399	668	5,566	6,634[b]
Uninsured	114	127	418	659
Percent of income class uninsured	**28**	**19**	**8**	**10**
New York				
Population in income class	2,127	2,143	11,097	15,367
Uninsured	358	470	1,027	1,855
Percent of income class uninsured	**17**	**22**	**9**	**12**

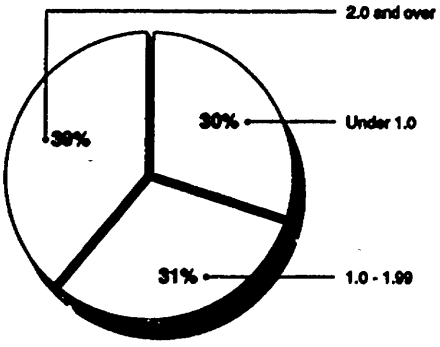
(continued)

	Ratio of family income to poverty level			
	Under 1.0	1.0-1.99	2.0 and over	Total
North Carolina				
Population in income class	651	1,109	3,816	5,576
Uninsured	226	247	314	787
Percent of income class uninsured	**35**	**22**	**8**	**14**
Ohio				
Population in income class	1,251	1,675	6,791	9,717
Uninsured	251	324	368	943
Percent of income class uninsured	**20**	**19**	**5**	**10**
Pennsylvania				
Population in income class	1,060	1,717	7,627	10,406[b]
Uninsured	229	269	423	921
Percent of income class uninsured	**22**	**16**	**6**	**9**
Tennessee				
Population in income class	774	921	2,608	4,303
Uninsured	214	283	147	644
Percent of income class uninsured	**28**	**31**	**6**	**15**
Texas				
Population in income class	2,755	3,020	9,446	15,221
Uninsured	1,589	1,258	1,100	3,946
Percent of income class uninsured	**58**	**42**	**12**	**26**
Virginia				
Population in income class	573	697	4,042	5,312
Uninsured	191	175	306	671
Percent of income class uninsured	**33**	**25**	**8**	**13**
United States				
Population in income class	28,419	37,240	149,004	214,663
Uninsured	9,658	10,133	12,614	32,405
Percent of income class uninsured	**34**	**27**	**9**	**15**

[a]The data include only people under age 65.

[b]Numbers do not add to total due to rounding.

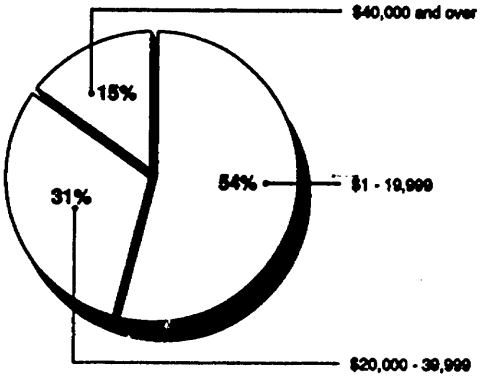
Figure V.2: Most Uninsured in the United States Have Incomes Less Than Twice the Poverty Level (1988)



Note: Includes only people under age 65. This chart shows the percentage distribution of the uninsured in poverty level ranges. Income is shown above as a multiple of the poverty level. Table V.1 shows the distribution of uninsured workers in numbers.

Source: Bureau of the Census, CPS (Washington, D.C., 1988).

Figure V.3: Most Uninsured Workers in the United States Have Incomes Less Than $20,000 per Year (1988)



Note: Includes only people aged 19-64. Percentage of uninsured workers in income ranges in the United States is shown in table V.2.

Source: Bureau of the Census, CPS (Washington, D.C., 1988).

Table V.2: Most Uninsured Workers in 15 States Generally Had Incomes Less Than $20,000 per Year (1986)[a]

	Percent of uninsured workers in personal income ranges					
	$1-9,999	$10,000-19,999	$20,000-29,999	$30,000-39,999	$40,000 and over	Total[b]
Alabama						
Full-time/full-year	1	13	9	8	5	36
Part-time/part-year	33	22	7	3	0	66
Total[b]	34	36	15	11	5	100
California						
Full-time/full-year	3	12	13	11	13	52
Part-time/part-year	21	14	6	4	4	49
Total[b]	23	27	19	14	17	100
Florida						
Full-time/full-year	3	11	15	10	12	51
Part-time/part-year	22	17	6	3	2	49
Total[b]	25	28	21	12	14	100
Georgia						
Full-time/full-year	4	16	11	8	9	48
Part-time/part-year	25	16	6	3	4	54
Total[b]	29	32	16	11	13	100
Illinois						
Full-time/full-year	2	14	14	7	10	47
Part-time/part-year	20	19	6	4	4	53
Total[b]	23	33	20	11	14	100
Louisiana						
Full-time/full-year	1	9	13	7	9	39
Part-time/part-year	32	15	8	3	3	61
Total[b]	34	24	21	10	12	100
Michigan						
Full-time/full-year	2	10	12	7	14	45
Part-time/part-year	27	13	8	2	5	55
Total[b]	29	23	20	9	18	100
New Jersey						
Full-time/full-year	1	12	13	11	18	55
Part-time/part-year	12	17	8	3	5	45
Total[b]	13	29	21	14	24	100
New York						
Full-time/full-year	3	8	14	10	20	55
Part-time/part-year	14	16	7	4	5	45
Total[b]	17	24	21	13	25	100

(continued)

	Percent of uninsured workers in personal income ranges					
	$1-9,999	$10,000-19,999	$20,000-29,999	$30,000-39,999	$40,000 and over	Total[b]
North Carolina						
Full-time/full-year	3	11	15	7	10	46
Part-time/part-year	27	14	7	4	3	54
Total[b]	29	25	22	11	13	100
Ohio						
Full-time/full-year	2	10	9	5	9	34
Part-time/part-year	27	21	9	5	5	66
Total[b]	29	30	18	10	13	100
Pennsylvania						
Full-time/full-year	4	8	13	10	10	45
Part-time/part-year	27	15	7	2	5	55
Total[b]	31	23	20	12	15	100
Tennessee						
Full-time/full-year	2	20	12	2	9	44
Part-time/part-year	21	19	9	3	4	56
Total[b]	23	39	20	5	12	100
Texas						
Full-time/full-year	3	13	14	6	9	45
Part-time/part-year	26	16	7	3	2	55
Total[b]	29	30	21	9	12	100
Virginia						
Full-time/full-year	1	9	15	11	15	51
Part-time/part-year	23	12	10	2	2	49
Total[b]	24	21	25	14	17	100
United States						
Full-time/full-year	3	11	13	8	11	46
Part-time/part-year	24	17	7	3	3	54
Total[b]	26	28	20	11	15	100

[a]The data include workers aged 19-64.

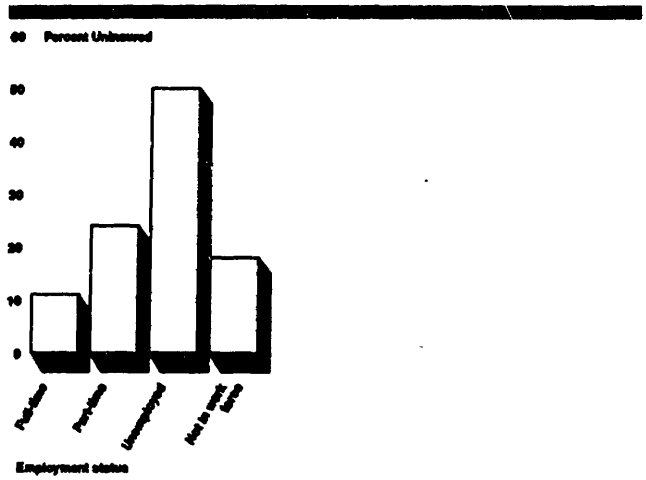
[b]Numbers may not add to total due to rounding.

Appendix VI

Uninsured Rates by Employment Status

This appendix shows uninsured rates for the United States and 15 states by employment status groups—full-time/full-year, part-time/part-year, unemployed, and not in the work force. Also shown are uninsured rates within employed populations. Table VI.1 shows uninsured rates for the population aged 19-64 by employment status, while table VI.2 shows the distribution of the uninsured population across the employment status groups.

Figure VI.1: Uninsured Rate Is Highest Among the Unemployed in the United States (1988)



Note The data include only people aged 19-64
Source Bureau of the Census, CPS (Washington, D C , 1988).

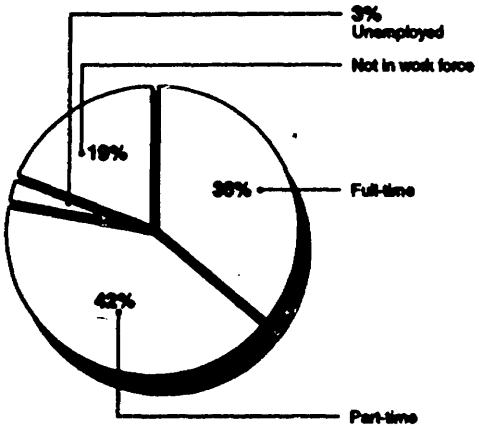
Table VI.1: The Unemployed and Part-Time/Part-Year Workers Had Higher Uninsured Rates (1988)[a]

State	Percentage of uninsured population within employment status group			
	Full-time/ full-year	Part-time/ part-year	Unemployed	Not in work force
Alabama	11	36	[b]	22
California	16	28	60	23
Florida	15	29	[b]	25
Georgia	13	32	[b]	17
Illinois	8	19	34	15
Louisiana	17	37	31	25
Michigan	7	14	[b]	9
New Jersey	8	16	[b]	13
New York	10	19	56	13
North Carolina	9	23	[b]	18
Ohio	6	19	35	11
Pennsylvania	6	15	46	12
Tennessee	10	20	[b]	22
Texas	17	36	68	30
Virginia	9	21	[b]	13
United States	11	24	50	18

[a]The data include only people aged 19-64.

[b]The population base is too small to estimate a useful percent of uninsured

Figure VI.2: Most Uninsured in the United States Aged 18-64 Were Employed (1988)



Source: Bureau of the Census, CPS (Washington, D.C., 1988).

Table VI.2: The Majority of the Uninsured Aged 19-64 in the 15 States Were Employed (1988)

State	Percentage of uninsured population by employment status group				
	Full-time/ full-year	Part-time/ part-year	Unemployed	Not in work force	Total
Alabama	27	50	2	22	100[a]
California	41	38	2	20	100[a]
Florida	39	38	2	21	100
Georgia	40	44	1	15	100
Illinois	36	39	4	21	100
Louisiana	29	44	5	22	100
Michigan	35	43	4	18	100
New Jersey	43	34	4	19	100
New York	41	33	3	22	100[a]
North Carolina	37	43	2	19	100[a]
Ohio	26	52	4	18	100
Pennsylvania	33	39	5	23	100
Tennessee	29	36	7	26	100
Texas	35	43	3	20	100[a]
Virginia	40	38	7	16	100[a]
United States	36	42	3	19	100

[a]Numbers may not add to total due to rounding

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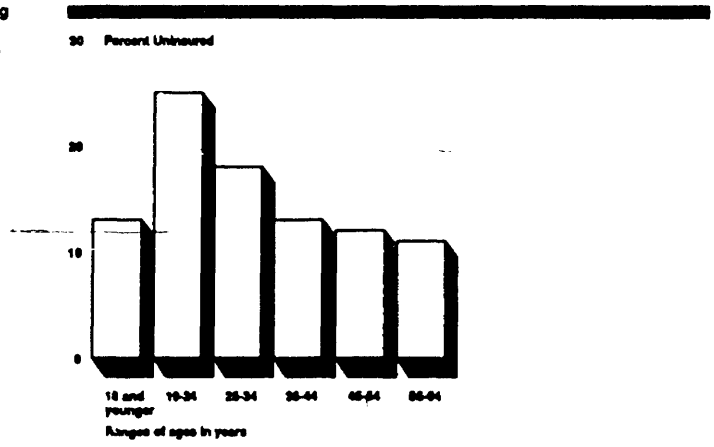
Appendix VII

Uninsured Rates by Demographic Characteristics

This appendix contains uninsured rates by certain demographic characteristics and highlights the type of individuals that are most likely to be uninsured. The characteristics included are age, race and ethnic origin, education, and marital status.

Figure VII.1: The Likelihood of Being Uninsured in the United States Is Greatest Among Those Aged 19-24 (1988)

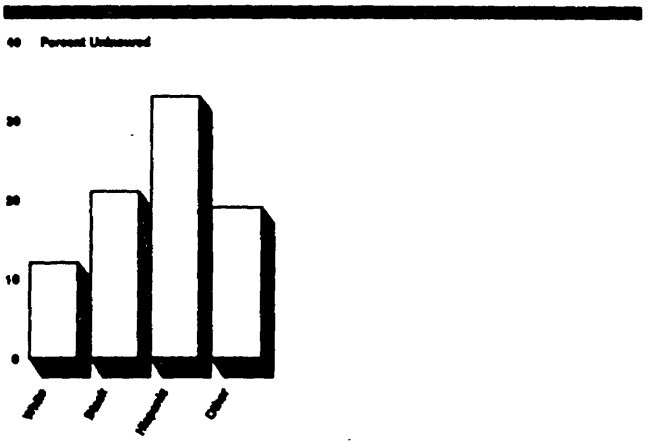


Note: Percentage of uninsured within age groups in the United States is shown in table VII.1.
Source: Bureau of the Census, CPS (Washington, D.C.: 1988).

Table VII.1: The Likelihood of Being Uninsured in the 15 States Is Greater Among Those Aged 19-24 (1988)

	Percentage of uninsured within age group					
State	18 and younger	19-24	25-34	35-44	45-54	55-64
Alabama	18	31	25	17	11	15
California	17	35	23	16	16	15
Florida	22	28	26	17	17	16
Georgia	16	30	20	18	11	13
Illinois	9	20	16	9	7	10
Louisiana	25	25	31	27	19	16
Michigan	4	12	11	6	8	6
New Jersey	7	20	13	8	8	8
New York	9	20	16	11	11	9
North Carolina	14	23	15	12	10	11
Ohio	7	20	13	8	7	8
Pennsylvania	7	18	10	8	9	8
Tennessee	13	19	21	14	14	10
Texas	27	37	29	22	18	18
Virginia	11	21	14	11	14	9
United States	13	25	18	13	12	11

Figure VII.2: The Likelihood of Being Uninsured in the United States Is Greater Among Minorities (1988)



Note: Includes only people under age 65. Percentage of uninsured within racial/ethnic groups in the United States is shown in table VII.2.

Source: Bureau of the Census, CPS (Washington, D.C., 1988).

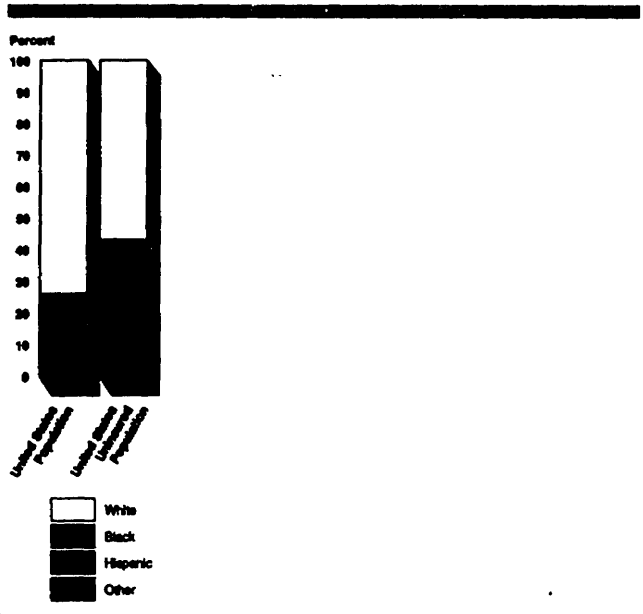
Table VII.2: The Likelihood of Being Uninsured in the 15 States Is Greater Among Minorities (1998)[a]

	Percentage of uninsured within racial/ethnic groups		
State	White	Black	Hispanic
Alabama	16	28	*
California	13	15	35
Florida	16	28	39
Georgia	12	28	*
Illinois	9	17	22
Louisiana	21	34	*
Michigan	7	13	10
New Jersey	8	14	24
New York	9	18	21
North Carolina	11	23	*
Ohio	9	11	17
Pennsylvania	8	14	6
Tennessee	14	17	*
Texas	16	27	47
Virginia	10	23	15
United States	12	21	33

[a]The data are for persons under age 65.

*The population base is too small to estimate a reliable percentage of uninsured.

Figure VII.3: Minorities Make Up a Disproportionately Large Segment of the Uninsured Population in the United States (1988)



Note: Includes only people under age 65. Percentage of the United States population as a whole and the population uninsured are shown in table VII.3.

Source: Bureau of the Census, CPS (Washington, D.C., 1988)

Table VII.3: Minorities Make Up a Disproportionately Large Segment of the Uninsured Population in Most of the 15 States (1988)[a]

State	Distribution of populations by racial/ethnic group				
	White	Black	Hispanic	Other	Total
Alabama					
Population	71	28	[b]	[b]	100[c]
Uninsured	59	41	[b]	[b]	100
California					
Population	57	7	26	10	100
Uninsured	38	6	46	10	100
Florida					
Population	67	18	13	2	100
Uninsured	50	24	24	2	100
Georgia					
Population	61	37	1	1	100
Uninsured	40	57	2	1	100
Illinois					
Population	74	15	8	3	100
Uninsured	58	22	16	4	100
Louisiana					
Population	65	33	2	1	100[c]
Uninsured	54	44	2	[b]	100
Michigan					
Population	82	15	1	2	100
Uninsured	73	25	2	1	100[c]
New Jersey					
Population	75	12	9	4	100
Uninsured	57	17	22	5	100[c]
New York					
Population	70	14	12	4	100
Uninsured	51	21	21	7	100
North Carolina					
Population	76	21	1	2	100
Uninsured	61	35	1	2	100[c]
Ohio					
Population	87	12	1	1	100[c]
Uninsured	84	13	2	[b]	100[c]
Pennsylvania					
Population	88	9	2	2	100[c]
Uninsured	81	13	1	5	100
Tennessee					
Population	80	19	[b]	1	100
Uninsured	77	21	[b]	2	100

(continued)

Appendix VII
Uninsured Rates by
Demographic Characteristics

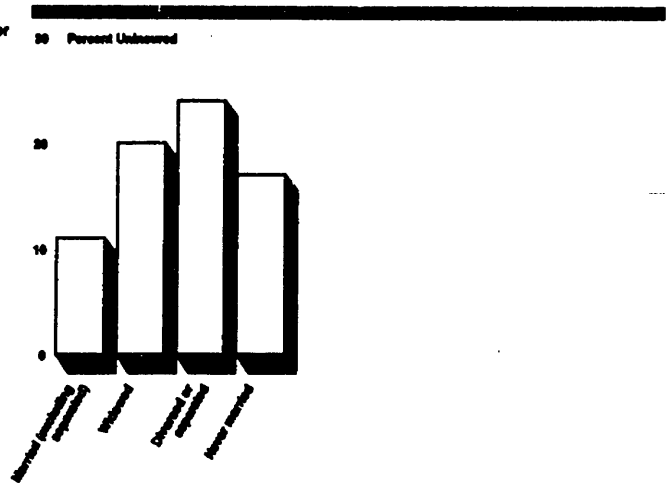
State	Distribution of populations by racial/ethnic group				
	White	Black	Hispanic	Other	Total
Texas					
Population	59	13	27	2	100[c]
Uninsured	37	13	49	1	100
Virginia					
Population	76	19	2	3	100
Uninsured	59	35	2	4	100
United States					
Population	75	13	9	4	100[c]
Uninsured	58	18	20	5	100[c]

[a]The data include only people under age 65.

[b]Less than 1 percent of the uninsured in the state are represented by this racial/ethnic group.

[c]Numbers do not add due to rounding.

Figure VII.4: The Likelihood of Being Uninsured in the United States Is Greater Among the Separated and Unmarried (1988)



Note: Includes only people under age 65. The Bureau of the Census classifies individuals' marital status according to four major categories: married, widowed, divorced, and never married. Married persons reported as "separated" include those with legal separations, those living apart with intentions of obtaining a divorce, and other persons permanently or temporarily estranged from their spouses because of marital discord. Percentage of uninsured within marital status groups in the United States is shown in table VII.4.

Source: Bureau of the Census, CPS (Washington, D.C., 1988).

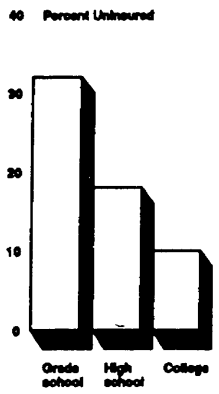
Table VII.4: The Likelihood of Being Uninsured in Most of the 15 States Is Greater Among the Separated and Unmarried (1988)[a]

State	Percentage of uninsured within marital status group			
	Married (excluding separated)	Widowed	Divorced or separated	Never married
Alabama	15	[b]	33	21
California	16	33	21	22
Florida	16	26	27	24
Georgia	13	29	28	20
Illinois	6	22	24	14
Louisiana	19	22	43	27
Michigan	5	11	14	9
New Jersey	5	15	17	13
New York	9	16	20	14
North Carolina	9	26	20	17
Ohio	6	18	19	12
Pennsylvania	6	12	18	10
Tennessee	12	6	23	17
Texas	21	32	33	29
Virginia	7	21	23	16
United States	11	20	24	17

[a]The data include only people under age 65

[b]The population base is too small to estimate a useful percent of uninsured

Figure VII.5: The Likelihood of Being Uninsured in the United States Is Greater Among Those With No More Than a Grade School Education (1988)



Note: Includes only people under age 65. Percentage of uninsured within educational levels in the United States is shown in table VII.5.

Source: Bureau of the Census, CPS (Washington, D.C., 1988).

Table VII.5: The Likelihood of Being Uninsured in 15 States Is Greater Among Those With No More Than a Grade School Education (1988)[a]

State	Percentage of uninsured within educational status group		
	Grade school	High school	College
Alabama	31	22	12
California	49	22	13
Florida	40	25	13
Georgia	27	22	11
Illinois	28	13	9
Louisiana	33	31	14
Michigan	18	11	5
New Jersey	24	13	7
New York	20	15	10
North Carolina	22	17	9
Ohio	13	12	8
Pennsylvania	18	11	7
Tennessee	26	15	12
Texas	54	29	13
Virginia	31	18	5
United States	32	18	10

[a]The data include only people under age 65

Appendix VIII

Sampling Errors of Percentages

This appendix contains sampling errors for percentages of uninsured individuals shown in all tables in appendixes IV through VII. The sampling errors are computed at the 95-percent confidence level. The Bureau of the Census recommends when using CPS data, that care be exercised when interpreting analysis results based on a relatively small number of cases or on small differences between estimates. Census maintains that valid estimates cannot be made where the population base is 75,000 or less.

Table VIII.1: Sampling Errors (Percentage Points) for Table IV.1

State	Uninsured percentages of worker populations by combined industry category		
	Manufacturing	Services	Other
Alabama	5	4	8
California	3	1	3
Florida	4	2	4
Georgia	5	3	6
Illinois	3	2	4
Louisiana	10	4	8
Michigan	2	2	5
New Jersey	3	2	4
New York	3	1	3
North Carolina	3	3	6
Ohio	2	2	4
Pennsylvania	2	2	3
Tennessee	4	3	6
Texas	4	2	4
Virginia	5	2	6
United States	1	0	1

Table VIII.2: Sampling Errors (Percentage Points) for Table V.1

State	Uninsured percentages of population groups based on the ratio of their family income to the poverty level			
	Under 1.0	1.0-1.99	2.0 and over	Total
Alabama	10	8	3	3
California	4	4	1	1
Florida	7	5	2	2
Georgia	9	7	2	3
Illinois	6	5	1	2
Louisiana	8	8	4	3
Michigan	6	5	1	1
New Jersey	11	8	2	2
New York	4	4	1	1
North Carolina	9	6	2	2
Ohio	6	5	1	1
Pennsylvania	6	4	1	1
Tennessee	8	8	2	3
Texas	5	4	2	2
Virginia	10	8	2	2
United States	1	1	0	0

Table VIII.3: Sampling Errors (Percentage Points) for Table V.2

State	Percentages of uninsured workers by personal income range: $1-9,999	$10,000-19,999	$20,000-29,999	$30,000-39,999	$40,000 and over	Total
Alabama						
Full-time/full-year	1	6	5	5	4	8
Part-time/part-year	8	7	4	3	0	8
Total	8	8	6	5	4	
California						
Full-time/full-year	1	2	2	2	2	3
Part-time/part-year	2	2	1	1	1	3
Total	3	3	2	2	2	
Florida						
Full-time/full-year	2	3	3	3	3	5
Part-time/part-year	4	4	2	2	1	5
Total	4	4	4	3	3	
Georgia						
Full-time/full-year	2	5	4	4	4	7
Part-time/part-year	6	5	3	2	3	7
Total	6	6	5	4	4	
Illinois						
Full-time/full-year	2	4	4	3	4	6
Part-time/part-year	5	5	3	2	2	6
Total	5	6	5	4	4	
Louisiana						
Full-time/full-year	2	4	5	4	4	7
Part-time/part-year	7	5	4	3	3	7
Total	7	7	6	5	5	
Michigan						
Full-time/full-year	2	5	5	4	5	8
Part-time/part-year	7	5	4	2	3	8
Total	7	7	6	5	6	
New Jersey						
Full-time/full-year	2	5	5	5	6	8
Part-time/part-year	5	6	4	3	4	8
Total	5	7	7	6	7	
New York						
Full-time/full-year	2	3	3	3	4	5
Part-time/part-year	3	4	3	2	2	5
Total	4	4	4	3	4	

(continued)

State	Percentages of uninsured workers by personal income range					
	$1-9,999	$10,000-19,999	$20,000-29,999	$30,000-39,999	$40,000 and over	Total
North Carolina						
Full-time/full-year	3	5	6	4	5	8
Part-time/part-year	7	5	4	3	3	8
Total	7	7	7	5	5	
Ohio						
Full-time/full-year	2	4	4	3	4	7
Part-time/part-year	6	6	4	3	3	7
Total	6	6	5	4	5	
Pennsylvania						
Full-time/full-year	3	4	5	4	4	7
Part-time/part-year	6	5	4	2	3	7
Total	7	6	6	5	5	
Tennessee						
Full-time/full-year	2	7	6	3	5	9
Part-time/part-year	8	7	5	3	4	9
Total	8	9	7	4	6	
Texas						
Full-time/full-year	1	3	3	2	2	4
Part-time/part-year	3	3	2	1	1	4
Total	3	3	3	2	2	
Virginia						
Full-time/full-year	2	5	6	5	6	8
Part-time/part-year	7	5	5	3	2	8
Total	7	7	7	6	6	
United States						
Full-time/full-year	1	2	3	2	2	4
Part-time/part-year	3	3	2	1	1	4
Total	3	3	3	2	3	

Table VIII.4: Sampling Errors (Percentage Points) for Table VI.1

	Uninsured percentages by employment status group			
State	Full-time/ full-year	Part-time/ part-year	Unemployed	Not in work force
Alabama	3	6	a	9
California	0	2	21	4
Florida	0	3	a	6
Georgia	0	5	a	7
Illinois	0	3	23	5
Louisiana	0	6	23	9
Michigan	0	3	a	4
New Jersey	0	3	a	6
New York	0	3	27	3
North Carolina	0	4	a	8
Ohio	0	3	27	5
Pennsylvania	0	3	28	4
Tennessee	0	4	a	9
Texas	0	3	22	6
Virginia	0	4	a	7
United States	0	1	7	1

[a]No sampling error was calculated because the population base is too small (less than 75,000)

Table VIII.5: Sampling Errors (Percentage Points) for Table VI.2

	Uninsured percentages by employment status group			
State	Full-time/ full-year	Part-time/ part-year	Unemployed	Not in work force
Alabama	7	8	2	6
California	3	3	1	2
Florida	4	4	1	3
Georgia	6	6	1	4
Illinois	5	5	2	4
Louisiana	6	6	3	5
Michigan	7	7	3	5
New Jersey	7	7	3	6
New York	4	4	2	4
North Carolina	7	7	2	5
Ohio	5	6	2	5
Pennsylvania	6	6	3	5
Tennessee	7	7	4	7
Texas	3	3	1	3
Virginia	7	7	4	5
United States	1	1	0	1

Table VIII.6: Sampling Errors (Percentage Points) for Table VII.1

	Uninsured percentages by age group					
State	18 and younger	19-24	25-34	35-44	45-54	55-64
Alabama	6	12	8	8	7	9
California	2	5	3	3	4	4
Florida	4	7	5	5	5	5
Georgia	4	9	6	7	6	7
Illinois	2	6	4	4	4	5
Louisiana	6	12	8	10	9	9
Michigan	2	6	4	3	4	4
New Jersey	3	8	5	4	5	5
New York	2	5	3	3	3	3
North Carolina	4	9	5	5	6	6
Ohio	2	6	4	3	4	4
Pennsylvania	2	6	3	3	4	4
Tennessee	5	10	7	6	7	7
Texas	3	6	4	4	5	5
Virginia	4	9	5	5	7	6
United States	1	1	1	1	1	1

Table VIII.7: Sampling Errors (Percentage Points) for Table VII.2

	Uninsured percentages by racial/ethnic group		
State	White	Black	Hispanic
Alabama	4	9	[a]
California	1	6	4
Florida	2	7	9
Georgia	3	6	[a]
Illinois	2	6	9
Louisiana	4	9	[a]
Michigan	2	6	19
New Jersey	2	8	11
New York	1	6	6
North Carolina	2	8	[a]
Ohio	2	6	24
Pennsylvania	1	8	13
Tennessee	3	8	[a]
Texas	2	7	5
Virginia	2	9	25
United States	0	2	2

[a]No sampling error was calculated because the population base is too small (less than 75,000).

Table VIII.6: Sampling Errors (Percentage Points) for Table VII.3

State	Percentages of populations by racial/ethnic group			
	White	Black	Hispanic	Other
Alabama				
Population	4	5	1	0
Uninsured	9	12	1	0
California				
Population	2	1	2	1
Uninsured	3	2	5	3
Florida				
Population	2	2	2	1
Uninsured	5	6	6	2
Georgia				
Population	3	4	1	1
Uninsured	8	10	3	2
Illinois				
Population	2	2	2	1
Uninsured	7	8	7	4
Louisiana				
Population	4	5	1	1
Uninsured	8	11	3	1
Michigan				
Population	2	3	1	1
Uninsured	9	11	3	2
New Jersey				
Population	3	3	2	2
Uninsured	10	10	11	5
New York				
Population	2	2	2	1
Uninsured	6	6	6	4
North Carolina				
Population	3	4	1	1
Uninsured	9	11	3	3
Ohio				
Population	2	2	1	0
Uninsured	6	7	3	1
Pennsylvania				
Population	2	2	1	1
Uninsured	6	7	2	4
Tennessee				
Population	3	4	1	1
Uninsured	8	11	0	4

(continued)

State	Percentages of populations by racial/ethnic group: White	Black	Hispanic	Other
Texas				
Population	2	2	2	1
Uninsured	4	4	5	1
Virginia				
Population	3	4	1	2
Uninsured	9	12	3	5
United States				
Population	0	0	0	0
Uninsured	1	1	1	1

Table VIII.9: Sampling Errors (Percentage Points) for Table VII.4

State	Uninsured percentages by marital status group: Married (excluding separated)	Widowed	Divorced or separated	Never married
Alabama	5	[a]	14	5
California	2	12	4	2
Florida	3	15	7	3
Georgia	3	20	9	4
Illinois	2	16	7	2
Louisiana	5	21	14	5
Michigan	2	13	7	2
New Jersey	2	16	9	3
New York	2	9	6	2
North Carolina	3	20	9	4
Ohio	2	14	7	2
Pennsylvania	2	11	8	2
Tennessee	4	14	11	4
Texas	3	16	7	3
Virginia	3	19	11	4
United States	1	3	2	1

[a]No sampling error was calculated because the population base is too small (less than 75,000)

Table VIII.10: Sampling Errors (Percentage Points) for Table VII.5

State	Uninsured percentages by educational status group		
	Grade school	High school	College
Alabama	13	5	6
California	6	2	2
Florida	10	3	3
Georgia	12	4	4
Illinois	10	3	3
Louisiana	13	6	6
Michigan	10	3	2
New Jersey	13	3	3
New York	7	2	2
North Carolina	11	4	4
Ohio	9	2	3
Pennsylvania	10	2	2
Tennessee	10	4	5
Texas	7	3	3
Virginia	12	4	2
United States	2	1	1

Appendix IX

Major Contributors to This Fact Sheet

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January 16, 1990.

Hon. DONALD W. RIEGLE, JR.,
U.S. Senate,
Washington, DC.

Dear Senator Riegle: We applaud your efforts in leading the Senate bipartisan working group on universal access to address the issue of assuring adequate and affordable health care coverage for all Americans. You and your colleagues are to be commended for your willingness to confront what are indeed challenging and pressing questions.

The physician community is equally committed to finding solutions which would provide access to health insurance for those estimated 31 million people who currently lack coverage.

The medical profession strongly believes the preferred solution is one which builds upon and preserves the strengths of the public/private system of employer-based insurance. We also understand that any health care reform proposal must attempt to correct some of the weaknesses and deficiencies within the health care system by addressing problems such as medical liability, the need for insurance market reform, and measures to reduce administrative burdens.

The undersigned physician organizations have formed a coalition to achieve enactment of legislation embodying the attached set of general principles. We are also continuing to work together to develop recommendations for improving the cost effectiveness of the delivery of quality medical services.

We hope that these principles and our efforts are of benefit to you and your colleagues. Please let us know if we can be of any help in the future.

Sincerely,

PHYSICIAN ORGANIZATIONS FOR ACCESS TO CARE:

American Academy of Family Physicians; American Academy of Neurology; American Academy of Ophthalmology; American Academy of Orthopaedic Surgeons; American Academy of Otolaryngology—Head and Neck Surgery; American College of Emergency Physicians; American College of Rheumatology; Aerospace Medical Association; American Medical Association; American Pediatric Surgical Association; American Psychiatric Association; American Society of Addiction Medicine; American Society of Anesthesiologists; American Society of Internal Medicine; American Society of Plastic and Reconstructive Surgeons; College of American Pathologists

Attachment.

STATEMENT OF PRINCIPLES ON ACCESS TO HEALTH CARE, A BLUEPRINT FOR COVERING THE UNINSURED

The health care needs of the uninsured population, a significant percentage of which are children, make it imperative that Congress enact legislation this year guaranteeing access to adequate and affordable health care coverage for all Americans. The medical profession has historically maintained that health care services be available to all our citizens and is strongly committed to finding solutions to assure access to health insurance for the estimated 31 million people in this country who currently lack coverage.

The undersigned medical organizations believe the preferred approach is one that builds upon the strengths of the public/private system of insurance and which contains the following essential elements:

- Utilizing the traditional approach of employer based insurance, employers should be required to provide health insurance to their employees and dependents with appropriate cost-sharing by employees. Recognizing the potential financial burden this could impose on certain small businesses, Congress should include provisions which would ameliorate the impact of this requirement such as tax relief, subsidies, phased-in implementation, risk pools and other reforms which would make insurance more available and affordable.
- Medicaid must be both expanded and substantially improved including the enactment of minimum eligibility and benefit levels, and incentives to enhance provider participation. Due to uneven eligibility criteria and benefit levels across the states, the current Medicaid program covers fewer than 42% of Americans with incomes below 100% of the Federal poverty level.

• For those who are not eligible for employer based insurance and who have incomes in excess of the enhanced Medicaid eligibility level, provision should be made for participation in a subsidized program with cost-sharing on a sliding scale premium basis.
• Health insurance programs, whether public or private, should provide access to basic physical and mental health benefits.

We are committed to working with the Congress and the Administration to achieve enactment of legislation embodying these principles. Further, in order to meet the immediate challenge of the uninsured population, and the longer term challenge of a better health care system for all Americans, the medical profession recognizes its responsibility to work with others to assure quality care is delivered in a cost efficient manner. We can do no less. The health of the nation is reflected in the health of its people.

PREPARED STATEMENT OF CARL J. SCHRAMM

I am Carl J. Schramm President of the Health Insurance Association of America. HIAA is a trade association of 300 private health insurance companies which provide health insurance for 95 million Americans.

Mr. Chairman, the escalating spiral of health care costs continues to plague our society. The members of this committee have seen in exquisite detail its effects on the Medicare program. The poor have felt first-hand its ravages on Medicaid. The private health insurance market has been no less immune to its deleterious effects.

The small employer market provides one of the most vivid examples of how health care cost inflation continues to afflict our financing system. Faced with unrelenting demands to hold health care costs down, insurers and employers have intensified the search for ways to moderate premium increases. Leaving high-risk individuals out of group coverage has been one such response. The "excessive employer churning" that newspaper accounts often bring to our attention is largely a function of employers seeking the lowest available rate. We, too, constantly hear the charge by small employers that the presence of a high-risk individual in their group has made it impossible to obtain coverage at any price.

This dynamic is complicated further by the tumultuous labor market of the small employer. Small employers are far more likely than larger organizations to go in and out of business. Our own annual employer survey suggests that employees of small firms also are more likely to change jobs. Employee turnover among small, insured firms is about 23 percent annually and is twice that level for small employers without coverage. These factors contribute to the reluctance of such employers to offer coverage as well as the difficulties of serving the market.

As the complexities of the small employer market have grown and the likelihood of individuals' being separated from the financing system has increased, there is a growing perception that even if they have coverage, they stand a reasonable chance of losing it if they change employers, or if they have poor claims experience.

Mr. Chairman, we have now reached the point where substantial small employer market changes are needed if we are to serve the longer-term interests of small employers and meet the concerns of policymakers. Just last week the HIAA Board reaffirmed its commitment to the comprehensive set of recommendations adopted a year ago that we believe can be achieved in the context of a viable private marketplace. The essence of our proposals is to make certain changes in the market so that it provides substantially more predictability and protection to the purchasers of coverage. Let me emphasize that, to work, these changes will have to apply to all players in the small employer market. All competing entities in the small employer market, including non-insured benefit plans, would have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage.

The small employer market precepts we recommend are:

1. If a carrier chooses to cover an employer group, it would be required to accept the whole group. Individuals could not be excluded from coverage within the group for health reasons.
2. At renewal time, employer groups and/or individuals within these groups would be assured that their coverage would not be canceled because their health had deteriorated.
3. Given the frequency with which small employers change carriers and employees in this market change jobs, individuals should have greater protection when making such moves. Therefore, when individuals are covered in the system, they

would not have to face new preexisting condition restrictions, once those requirements have been fulfilled, in the event that they change jobs or their employer changes carriers.

4. There should be meaningful limits on how much an insurance carrier's rates could vary for employer groups of similar composition (similar demography, geography, benefit design and industry). This also would involve limits on how much a carrier could raise its rates for a specific group above and beyond general increases in trend factors.

5. Insurance carriers would retain the right to medically underwrite for purposes of assessing risk and setting rates but not to exclude individuals from coverage in a group plan.

6. Finally, a major objective of these reforms should be to ensure a viable private marketplace over the long term.

These precepts were adopted by the Board with the understanding that they will exact some pain from the industry in the short term, but are critical for coverage of the small employer over the longer term. They represent our industry' s commitment to meeting the needs of the small employer community by providing a responsive insurance marketplace.

To give effect to these proposals, government must authorize a private not-for-profit reinsurance organization: Otherwise, these reforms are not achievable. This organization would allow carriers to pay a premium in exchange for haying the reinsurer bear the risk for reinsured individuals. Consistent with the small employer market changes, the proposal does not envision breaking up groups for purposes of reinsurance. Rather, insurers would treat all individuals in a group the same way; all members would have the same benefits. The reinsurer would stand behind the carrier and simply reimburse for claims associated with reinsured individuals. This will allow us to assure that high risks are spread, broadly through the private market rather than concentrated in one small employer group.

The reinsurance mechanism naturally would sustain financial losses or shortfalls, since carriers would reinsure only persons whose claims are expected to exceed the price of reinsurance. The intent of the proposal is that losses be financed privately. Losses first would be spread across carriers in the small employer market through an assessment of up to four percent of premium, except in states where general funds would be dedicated for this purpose. If losses were not absorbed fully by the small employer market, a second tier of losses would be spread more broadly.

These proposals will assure that no small employer, and no employee of a small employer, will be turned down for health insurance because of poor health. They will restore the concept of pooling risk across large groups, greatly limiting how much of the cost of poor health must be borne by the individual employer. Further they will moderate significantly the sometimes dramatic premium increases now experienced by small employers at renewal time and thereby reduce the incentive to change carriers frequently.

With our recommended market changes in place, the small employer will stand to benefit greatly from our rapidly evolving cost management capacity. These reforms will encourage competition based on efficiency rather than selection. Competitors would no longer be allowed to draw business away from more efficient health benefit plans by offering temporarily low prices that skyrocket once an employee gets sick. Insurers that reduce inefficient administrative costs and that offer cost-effective financing systems and delivery networks will gain a larger share of what is an extremely price-sensitive market.

Mr. Chairman, we are working aggressively with the National Association of Insurance Commissioners to implement these reforms in the states. Connecticut has already enacted its version of these reforms with industry support, and in the past year we have presented our proposal in approximately 30 other states. We expect to have state model legislation in the very near future for use in every state.

There are other steps that Congress should take now to assist small employers with the high cost of health care.

First, the existing preemption of state mandatory benefit laws that currently applies to self-insured employee health plans should be extended to insured plans. There are over 800 different state mandated benefit laws nationwide, ranging from acupuncture and Chinese medicine to pastoral counseling and mental health benefits, from wigs to in vitro fertilization. The cumulative effect is a hodgepodge of state laws that increase the cost of health insurance to small employers who are most in need of relief from the high cost of health care. Small employers should not be forced to choose between a "Cadillac" plan and none at all.

A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of the added cost of state mandates.

Second, owner-employees of small businesses should not be forced to incorporate to get a 100 percent deduction for their health insurance plan. The 25 percent deduction which expires this year should be extended and increased, giving self-employed individuals a 100 percent deduction for their health insurance protection as long as they provide equal coverage to any employees.

Third, while we are pleased that Congress did in 1990 adopt Medicaid changes recommended and supported by the HIAA, more remains to be done. We continue to recommend that all Americans with family income below the poverty line be covered by Medicaid, regardless of family structure, age, or employment status, with Medicaid eligibility independent of cash assistance programs. "Spend down" programs should be extended to all states and low-income individuals above the poverty level should be allowed to "buy into" an income-related package of primary and preventive care.

Mr. Chairman, I want to emphasize that it is definitely not business as usual in the insurance industry. Besides the small group market insurance reforms which I have already discussed, the nation's insurers are moving on their own against what we know to be the root cause of so many of our problems, the ever spiralling cost of health care. One of the most effective means to obtain cost control is to improve our health care delivery and financing system through effective managed care programs. Spurred by customer demands for greater control of medical care expenses, commercial insurers began during the 1980's to transform their business—from claims payer to manager of health care delivery systems. This was a major departure from their former passive role as financier. Today, insurers are making major investments in improved medical management systems to assure that the health care delivery system provides appropriate care before approval for payment is made.

Has managed care proved that it can control costs? There is ample and persuasive evidence that early forms of managed care were effective in controlling costs. The classic study of cost performance in managed care is the Rand Study of HMOs conducted in the mid 1970's. The results were dramatic: the calculated expenditures in the NO were about 25 percent less than that of a fee-for-service control group. Studies conducted in the mid to late 1982 have been consistent with past studies, showing savings that fall within the 20 percent to 25 percent range. The latest report card on managed care also looks quite good. A study by Laventhol and Horwath to assess the cost savings of managed care in the CHAMPUS Reform Initiative indicates that managed care saved Defense Department and CHAMPUS beneficiaries $148.9 million in 1988 and 1989. The precedent setting Point-of-Service managed care plan between Cigna and Allied Signal has produced excellent results. Allied Signal estimates that the managed care plan saved the firm about $750 per employee in 1990.

Will managed care continue to be cost saving? Our nations business leaders think so. According to a survey of Fortune 1000 senior executives conduced by the Roper Organization, Inc., more than two-thirds believe that controlling health costs through managed care entities such as health maintenance organizations and preferred provider organizations is, or could be effective. In addition, they recognize that the private sector should take responsibility for addressing the cost problem through the private/public partnership that currently exists. An overwhelming 94% of those polled oppose national health insurance as a solution to rising costs. Major purchasers are insisting on delivery system improvements by implementing managed care for their employees. Recent examples include AT&T, Xerox, Wells Fargo, Bell South, Bell Atlantic, and Allied Signal.

Growth is also a clear indication that employers are turning to managed care as a means of controlling costs and adding value for the dollar. Despite having origins in the 1930's and 1940's, managed care evolved and grew slowly until the past decade. In 1980, 9 million people were enrolled in HMO's. By 1990, 34 million were HMO enrollees and an astounding 34 million were covered by PPO plans, bringing the total number of people covered by managed care to 68 million.

Recognizing the need to improve the quality and efficiency of care, commercial insurers have moved rapidly to adopt managed care programs and techniques. In 1982, managed care constituted less than 2% of group business. By the end of the decade more than 26% of group business was managed care. By 1988, about one of every seven insurers in the employer—based market offered an 10 product; more than half sold a PPO product. Commercial insurers accounted for about one fifth of HMO subscribers and one third of PPO enrollment in 1988.

For very good reasons, those who are presented with alternative health care delivery systems are becoming prudent buyers, asking what they get for the dollars they spend. Concerns about quality of care are a major focus of those questions. Evidence shows that cost control and enhanced quality of care are not mutually exclusive goals. Under managed care, insurers should serve as "purchasing agents" for patients, with the responsibility of ensuring they do not pay for inappropriate care. The broad spectrum of activities of managed care are directed at assuring quality of care while controlling costs.

Managed care has demonstrated that quality of care can be enhanced as a result of its activities. Studies comparing the quality of care in managed care and traditional fee-for-service delivery which were conducted in the 1970's and reports as recent as 1988 consistently show that the quality of care in managed care is at least equivalent to the care in traditional forms of health care delivery. The RAND controlled experiment provided the first definite evidence in the mid 1970's and a report by Harold S. Luft on "HMO's and the Quality of Care" in 1988 reach a similar conclusion.

As insurers become more active in the management of health care delivery, they are developing a new partnership with physicians. Managed care strategies recognize that physician practice patterns vary widely, with no evidence that more resource—intensive styles of care result in superior outcomes. By examining physicians practice patterns and measuring outcomes, managed care is able to identify cost effective providers. The managed care purchaser develops a network of cost-effective providers and negotiates a favorable price with them. Managed care can achieve greater efficiency to the extent that the primary decision makers in health care, the physician and the patient, share in the benefits of quality, cost effective care.

Commercial insurers are committed to controlling medical care expenses through managed care plans. Their unique partnership with American business and their influence in the evolution of managed care programs will promote the delivery of high quality care more cost effectively.

Working together with government, we think we can make a substantially better tomorrow for us all. Thank you.

COMMUNICATIONS

STATEMENT OF THE ASSOCIATION ON MINORITY HEALTH PROFESSIONS SCHOOLS

The Association of Minority Health Professions Schools (AMHPS) strongly supports reform of our national health care system which insures health care services to anyone who needs access to health care. Disparities in access to health care is the dominant factor which accounts for the growing disparity in the health status between blacks and other disadvantaged minorities and the general population of the U.S. Improved access to health care is of paramount importance in achieving the AMHPS mission to improve the health status of minority and disadvantaged persons. National health care reform is absolutely essential in order to address the crises of lack of access to proper health care for minorities. The Federal government must demonstrate leadership by addressing this crises now.

HEALTH STATUS DISPARITY

Blacks and other disadvantaged minorities do not enjoy the same health status as other Americans. The 1985 Health and Human Services Secretary's Task Force Report on Black and Minority Health demonstrated that there indeed was and is a significant health status disparity among blacks and other minorities as compared to the general population of the U.S.

Among the more sobering facts revealed by the report were:

- Life expectancy of blacks is nearly 6 years less than that of whites;
- Among blacks, infant mortality occurs at a rate of almost 20 per 1,000 live births, twice that of whites;
- Blacks suffer disproportionately higher rates of cancer, cardio-vascular disease and stroke, chemical dependency, diabetes, homicide and accidents; and
- Each year almost 60,000 excess deaths occur among blacks when compared to whites.

Since this historic report by the Secretary in 1985 the health status gap has widened. The National Center for Health Statistics recently reported that black life expectancy has decreased from 69.7 in 1984 to 69.2 in 1988. AIDS, which was not even mentioned in the 1985 report is now a leading cause of death and disproportionately affects blacks and other minorities—minorities who constitute 24% of the U.S. population but 45% of our AIDS victims.

AMHPS INSTITUTIONS

AMHPS is comprised of 8 historically black health professions schools which have trained 40% of the nation's black physicians, 40% of the nation's black dentists, 50% of the nation's black pharmacists, and 75% of the nation's black veterinarians.

AMHPS institutions each have a student body that is represented by more than 50% minorities. This is important in that data clearly show that blacks and other minorities are more likely to practice in underserved communities, more likely to care for other minorities and more likely to accept patients who are Medicaid recipients or otherwise poorer than the general population. While the Federal government's commitment to supporting historically black health professions schools has gone a long way toward addressing the disparity in the health status between minority and non-minority populations, AMHPS believes that in addressing the enormous problem of this health status disparity, a firm commitment from the Federal Government to the users and payors of health services must be made.

AMHPS institutions have been at the vanguard of addressing the enormous need to close the gap in the health status disparity between the minority and majority populations, to increasing the number of minorities in the health professions and to

serving the indigent and the underserved. There is a direct correlation in between these objectives and the causes of these problems which gave rise to our institutions' objectives. These objectives all emanate from the historical and tremendous problem of disparities between minority and majority populations in access to health care. For many years our institutions have been involved in minority health professional education and have established an outstanding track record in serving the underserved.

HEALTH CARE REFORM IS URGENT

There are approximately 37 million Americans who have no health insurance. Millions of disadvantaged Americans are not able to pay and receive health care. Employers who do provide health insurance, public hospitals and people with health insurance subsidize the costs of uncompensated care. The current situation is unacceptable and demands urgent action by the Federal government. Every day that health care reform is delayed, more blacks die. Every day that health care reform is delayed, minority health professions institutions experience greater financial instability.

From 1977 to 1987 the relative increase in the number of persons without insurance was greater among minorities than whites. During that time span, the number of uninsured whites increased by about 28 percent while the number of uninsured blacks nearly doubled from four to seven million and the number of uninsured Hispanics increased three-fold from two to six million. Thirty-five percent of Hispanics under age 65 and 26 percent of blacks, were uninsured in 1987 compared to 15 percent of whites. The increase between 1977 and 1987 in the proportion of uninsured Hispanics was five times the increase for whites. For blacks, the increase was twice that for whites. The declining proportion of blacks with health insurance is mainly due to a reduction in private insurance, with public coverage remaining essentially unchanged.

As the *1985 Secretary's Task Force on Black & Minority Health* revealed, "Many . . . minorities tend to rely on Medicaid and charity care for their medical treatment because they have no other sources of care or ways to finance that care . . . " Further, minorities are disproportionately poor and unemployed, consequently they disproportionately experience the barriers to health care associated with poverty. Under the current system of health care insurance, poor people are too often excluded from the process. Their is a correlation between the problem of criteria for eligibility into the process of health cost reimbursement and the problem of poor access to health care by the poor. Health care coverage is often provided through employment, so for minorities access to health care is often obstructed through unemployment as well as a lack of knowledge of health care availability. Many other barriers exist as a result of poverty which prevent access to health care, including lack of available health care personnel, transportation, and other cultural barriers. Economic and other barriers to the receipt of health care must be eliminated.

GENERAL RECOMMENDATIONS

AMHPS believes that the following general criteria are essential elements to any health care reform plan. The plan must provide (1) universal, comprehensive coverage. It must (2) maximize cost efficiency through cost containment and it must (3) maintain a free-enterprise component.

Improved access to health care for all Americans must be the primary component of health care reform. In his January 29th State of the Union address, President Bush stated that "good health care is every American's right and every American's responsibility." Access to health care should not relate to one's ability to pay. The issue must be placed on the national agenda immediately.

National Health Care Reform must also maximize cost efficiency. Health care costs have risen beyond control. The U.S. spends over 600 billion dollars per year on health care. Per capital health spending is greater in the United States than in Canada, yet our nation has a lower life expectancy and a higher rate of infant mortality. A national health care reform program should stabilize health expenditures as a percentage of the national income and reduce the problems of uncompensated care and individual burdens of catastrophic illness. In order to achieve these objectives such a plan must redirect available resources to the weaknesses of the system. Too often, funding that was originally intended to help the indigent does not reach the indigent. The flow of resources to the underserved is not being appropriately applied. A redirection of resources to institutions that provide quality care to the disadvantaged, to the underserved and to the indigent, is an important component

of any national health care reform program. There must also be a focus on preventive medicine and primary care.

Finally, a national health care reform program must maintain a free-enterprise component, that would allow for the continued provision of health care services by the most competent and accessible individuals or systems, at the most affordable and reasonable cost.

THE PROCESS

In the last year alone, several major health care associations, as well as the Pepper Commission have developed national health reform programs. Yet without Executive leadership and differences over the various aspects of the several proposals, no work has begun in Congress to enact a new health coverage program. Whether the means toward achieving universal access to health coverage include incentives for employers to provide health care coverage and support for public programs that provide access to basic health care benefits for the uninsured or not, what is important is to recognize that alleviating the problem of the health status disparity between disadvantaged minorities and the general population is crucial.

Black Americans are experiencing a health care crisis. The President and the Congress must exert leadership and enact legislation to improve access to health care for minorities. Action must not be delayed any longer.

MAYO FOUNDATION,
Rochester, MN, March 6, 1991.

Senator DONALD W. RIEGLE, JR., *Chairman,*
Subcommittee on Health for Families and the Uninsured,
Senate Committee on Finance,
Washington, DC.

Dear Senator Riegle: On behalf of the Mayo Foundation, I am submitting this statement for the record of the hearing held by your subcommittee on February 25, 1991.

Mayo Foundation—has adopted a set of health policy principles which we believe should serve as the basis for health care reforms that may ultimately be adopted by the nation. These eleven principles adopted by our Board of Trustees are attached. While there clearly are no easy answers to the problems within our nation's health care system, we hope that the articulation of the basic principles society wants its health care system to achieve will provide the appropriate infrastructure for specific proposals which ultimately will evolve.

We believe the current health care system does not meet many of these principles, especially the most important principle of basic health insurance coverage for all, regardless of ability to pay. We also believe that a single payer national health plan such as the Canadian system fails to meet the principles, would not promote medical innovation, and would not be consistent with U.S. societal values. Mayo has analyzed many reform proposals in light of the principles we espouse. In our view, those that build from the strengths of the current system are better able to meet the principles we have suggested.

We are now working to further define the Mayo principles. One area requiring intense study relates to the definition of "basic" health insurance coverage. We are attempting to develop a framework for further debate on this specific issue.

We welcome the opportunity to submit these comments for the record.

Sincerely,

ROBERT R. WALLER, M.D.

Attachment.

HEALTH POLICY PRINCIPLES

The Mayo Foundation recognizes that national health policy is an issue of major importance, and that a number of significant proposals have been made to reform the national health care system. While Mayo is not attempting to develop a specific proposal, we believe that certain principles should guide policy makers in developing national health policy.

(1) **Guaranteed basic level of health insurance coverage**—some basic level of health insurance coverage should be available to all, regardless of ability to pay, in order to ensure the societal good.

The definition of the basic level of coverage should be made at the Federal level, as well as the decision on how to guarantee individual coverage (employers, individuals, government).

(2) **Individual freedom to purchase additional services**—in order to promote freedom of choice, those who wish to purchase additional services should be free to do so, and should be free to purchase services outside of their coverage plan and without regard to plan reimbursement limits.

(3) **Freedom of choice**—the patient should be free to choose his or her own health care providers, or to voluntarily choose an insurance plan which limits provider choice. It is appropriate for insurers to use financial incentives to encourage the use of high quality, cost effective providers, as long as patients retain the right to choose other providers if they are willing to personally accept responsibility for additional costs incurred. Consumer choice is necessary to ensure quality care, competition, and innovation.

(4) **Private providers**—a system of multiple private providers of care should be maintained in order to guarantee freedom of choice and innovation.

(5) **Multiple payers**—a system of multiple payers should be maintained to ensure patient freedom of choice, competition, and innovation.

(6) **Reimbursement**—reimbursement should be adequate to ensure excellence and innovation, but should also provide incentives for efficiency and quality.

(7) **Patient responsibility**—in order to promote a more productive society, the system must encourage patients to take responsibility for their own health, through healthy lifestyles and cooperation in preventing illness and injury. Individuals should also be involved in decisions on their treatment, including decisions on when the use of life sustaining technology to prolong their own life is desired.

(8) **Education and research**—the system must ensure that adequate and identified funding for education and research is provided. The education system must ensure an adequate supply of medical personnel while maintaining high education standards. Medicine should increase research into the effectiveness of diagnostic and treatment modalities, and disseminate the results of such research to practicing physicians. Education and research are necessary to provide for continuously improving future health care.

(9) **Cost control**—high quality care must be provided in a cost efficient manner. A cost control program should include:

(A) *patient financial responsibility* through copayments and deductibles, as a method of controlling utilization and making better choices as to when to use the health care system,

(B) *research to develop practice guidelines* with the goal of eliminating unnecessary services as well as encouraging necessary services,

(C) *support for the testing of new technologies* in order to ensure that they improve outcomes in a cost effective manner,

(D) *malpractice reforms* to reduce defensive medicine and wasted resources,

(E) *elimination of State health insurance mandates* that go beyond the basic level established pursuant to paragraph (1).

(F) *uniform claim forms* for all third party payers in order to reduce administrative overhead costs,

(10) **Quality assurance and ethical standards**—patients should receive high quality care. In order to ensure the integrity of the health care system, physicians and other health care providers should practice in accordance with high quality and ethical standards enforced through a system of responsible peer review.

(11) **Volunteerism and philanthropy**—in order to address unmet health care needs, the system should encourage volunteerism and philanthropy.

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